

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7323 CERTIFICATE OF DEATH

07323

Reg. Dist. No. 21

1. PLACE OF DEATH ANNE ARUNDEL COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED 18 N Cherry St STATE MARYLAND COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 ANNAPOLIS		LENGTH OF STAY (in this place) LIFE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 ANNE ARUNDEL GEN'L HOSP		STREET ADDRESS (If rural give location) 18 N Cherry St	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) FRANK GEROD BAKER, SR		4. DATE OF DEATH (Month) (Day) (Year) AUG 1 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) D	8. DATE OF BIRTH MAY 28, 1887
9. AGE last birthday 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLUB MANAGER	
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN Wm Baker		14. MOTHER'S MAIDEN NAME Estelle Tydings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS SON: 101 DREAM'S LANDING			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute myocardial infarction ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			2 hrs 10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bleeding peptic ulcers			36 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/1/55, 1955, to 8/1/55, 1955, that I last saw the deceased alive on 8/1/55, 1955, end that death occurred at 10:30 M, from the causes end on the date stated above. 8/1/55 SIGNATURE John R. Hedeman M.D. 90 Cathedral St. Annapolis, Md ADDRESS DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 8-4-1955	NAME OF CEMETERY OR CREMATORY Asbury Church	LOCATION (City, town, or county) (State) Arnold, Md.
24. REC'D BY REGISTRAR DATE 8-3-1955	REGISTRAR'S SIGNATURE J. O. Daniel	25. FUNERAL DIRECTOR'S SIGNATURE J. M. Taylor Sr. Annapolis, Md.	

1

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7324 CERTIFICATE OF DEATH

07324

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		3 days		10 TOWN <u>Annapolis, Md. (Arnold)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
57 USNH, Annapolis, Md				USNH, Annapolis, Md.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month)	(Day)
Kenneth		Charles		BAKER		August	5
						19	55
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
M	Cau.	S	3 August 1955	yrs.	Months	Days	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Infant		Infant		Maryland		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Ernest BAKER				Ana Marie RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		-		USNH, Annapolis, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
762.5 IMMEDIATE CAUSE (A) <u>Atelectasis with immaturity # 762.5</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				3 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 8-3, 19-55, to 8-5, 19-55, that I last saw the deceased alive on 8-5, 19-55, and that death occurred at 1:15 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
E.R. PETERS LT MC USN				M.D. USNH, Annapolis, Maryland		5 Aug. 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug 8, 1955		Naval Cemetery		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE August 8, 1955				Hopping Funeral Home Annapolis, Md.			

21 85211302

13821

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

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AT WHAT RESIDENCE, HOUSE OR PLACE

Y. PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REPORTER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF SIGNER

BUREAU V. S.

AUG 10 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 151C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07325

7325

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		Years		TOWN <u>Annapolis</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				STREET ADDRESS (If rural give location) <u>813 Bay Ridge Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>DAVID COOKE BANKERT</u>				<u>Aug. 24. 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>Aug. 19, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>manager</u>		<u>hotel</u>		<u>Westminster, Md.</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>David J. Bankert</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Elizabeth G. Bankert, Annapolis, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>myocardial failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>rupture of appendix & abscess & localized abscess & local peritonitis</u>							
19a. DATE OF OPERATION <u>8/17/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>ruptured appendix & abscess & localized peritonitis</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 19, 1955</u>, to <u>Aug. 24, 1955</u>, that I last saw the deceased alive on <u>Aug. 24, 1955</u>, and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. B. Borman</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md.</u>		DATE SIGNED <u>8/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>8/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Carroll county, Md.</u>	
24. REC'D BY REGISTRAR <u>Wm. J. French</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. French</u>		ADDRESS <u>Union Bridge Md.</u>	
DATE <u>Aug. 29, 1955</u>							

1955 CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. SEX

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF OTHER

21. SIGNATURE OF DECEASED'S MOTHER

22. SIGNATURE OF DECEASED'S FATHER

23. SIGNATURE OF DECEASED'S SISTER

24. SIGNATURE OF DECEASED'S BROTHER

25. SIGNATURE OF DECEASED'S UNCLE

26. SIGNATURE OF DECEASED'S AUNT

27. SIGNATURE OF DECEASED'S GRANDFATHER

28. SIGNATURE OF DECEASED'S GRANDMOTHER

29. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

30. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

31. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

32. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

33. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

34. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

35. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

36. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

37. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

38. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

39. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

40. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

41. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

42. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

43. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

44. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

45. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

46. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

47. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

48. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

49. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

50. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

51. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

52. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

53. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

54. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

55. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

56. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

57. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

58. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

59. SIGNATURE OF DECEASED'S GREAT-GRANDFATHER

60. SIGNATURE OF DECEASED'S GREAT-GRANDMOTHER

BUREAU V. S.

AUG 29 1955

RECEIVED

7353

07326

Reg. Dist.

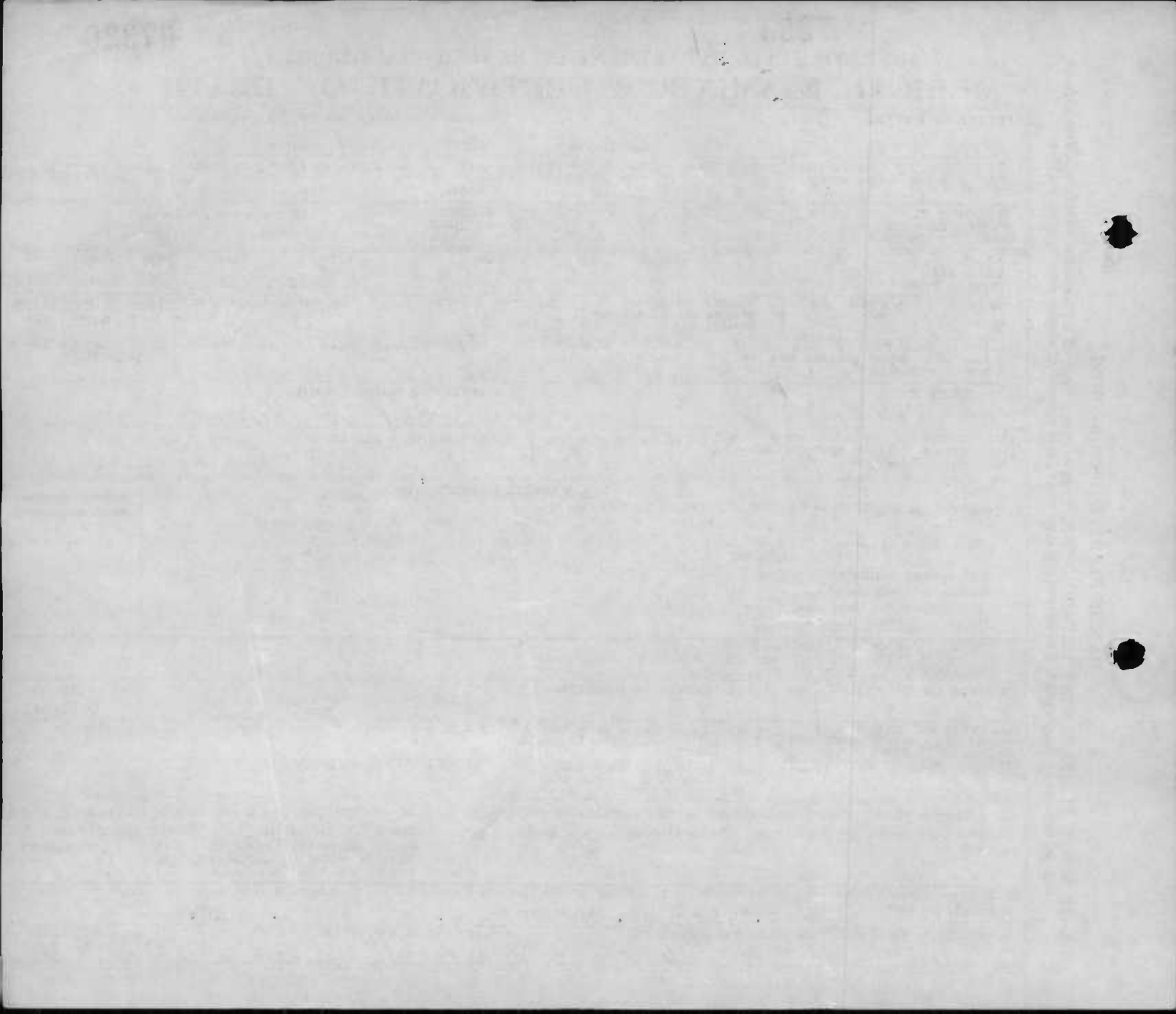
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *7353*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md.</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Severna Park</i>	LENGTH OF STAY (in this place) <i>4 months</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Baltimore</i> <i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old Annapolis Rd.</i>		STREET ADDRESS (If rural, give location) <i>1213 21st. Landow St</i> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Charles H.</i> (Middle) <i>Bennett</i> (Last)		(Month) <i>August</i> (Day) <i>30</i> (Year) <i>1955</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>Caucas.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Widowed</i>	8. DATE OF BIRTH: <i>4/4/86</i>
9. AGE last birthday: <i>69</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Retired Police</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Steven Bennett</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>217-07-2234</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Mrs. Edith Edmonds (niece)</i>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <i>Coronary Occlusion</i> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			<i>Sudden</i>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Edward H. Paubert MD</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>8/30/55</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>Sept. 3, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>	LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
DATE REC'D BY LOCAL REG. <i>Sept 1, 1955</i>	REGISTRAR'S SIGNATURE <i>C. W. Hedrick</i>	24. FUNERAL DIRECTOR <i>Mrs. Katie R. Williams</i> ADDRESS <i>322 Schroeder St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07327

7354

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Glen Burnie</u>				OR TOWN <u>Glen Burnie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>412 N Street SE</u>				STREET ADDRESS (If rural give location) <u>421 N. Street SE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ROSS A BENNINGTON</u>				<u>August 20, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 23, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James William Bennington</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Ashcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>208-01-2901</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth Bennington- wife- same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
DUE TO ANTECEDENT CAUSE(S) (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 1952</u> to <u>Aug. 1955</u> that I last saw the deceased alive on <u>9-18</u> 19 <u>55</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Chas Macdonald</u> M.D. <u>Glen Burnie Md</u> DATE SIGNED <u>8-20-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 23, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR <u>Aug-22-1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kinsley Funeral Home</u>		ADDRESS <u>Glen Burnie, Md.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7355

CERTIFICATE OF DEATH

07328

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>North Carolina</u>		COUNTY <u>Lenion</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort G. G. Meade,</u>		LENGTH OF STAY (in this place) <u>24 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kinston</u>		<u>70 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>1057 Waters Street</u>			
3. NAME OF DECEASED (Type or Print) <u>DEMETRIUS</u> (First) <u>ELMAS</u> (Middle) (Last) <u>BEST</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 18</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 16, 1955</u>		9. AGE last birthday yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse R. Best</u>				14. MOTHER'S MAIDEN NAME <u>Zelma Lee Bobbitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Apt. B 306 Suter Road</u> <u>Baltimore 28, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>776X Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Aug 55</u> to <u>18 Aug 55</u> that I last saw the deceased alive on <u>18 Aug 55</u> and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needelman</u>		M.D. <u>1st Lt. MC</u>		ADDRESS (Street, city, town, state) <u>Fort G. G. Meade, Md.</u>		DATE SIGNED <u>18 Aug 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>19 August 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort G.G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor</u>		REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>CHAPLAIN QUIGLEY</u>		ADDRESS <u>Fort G.G. Meade, Md.</u>	
DATE <u>18 August 1955</u>		CHAPLAIN <u>1st Lt. MC</u>					

2085326280

12328

CERTIFICATE OF DEATH

RECEIVED
AUG 22 1955
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07329

7356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>8 mos. 25 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>212 Clay Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Emma R. Boston</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>67 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Thomas Boston</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Makell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>220-24-8125</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Acute Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebro Vascular Accident</u>						<u>Since 8/6/55</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/24</u>, 19 <u>54</u>, to <u>8/18</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>8/18</u>, 19 <u>55</u>, and that death occurred at <u>12:05 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>(L. Benedict)</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>8/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>ANNA POLIS, Md</u>	
24. REC'D BY REGISTRAR DATE <u>Aug 30, 1953</u>		REGISTRAR'S SIGNATURE <u>Lothar M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II, 108 W. Wash. St Annapolis, Md</u>			

Elizabeth M. Kelly

Thomson's

2018-41-05

14

BUREAU V. 2.

AUG 30 1955

RECEIVED
AUG 30 1955

8-2-2018

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07330

7326

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | STATE <u>MD</u> COUNTY <u>AA</u> | | CITY (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> MD <u>10</u> | | OR TOWN <u>ANNAPOLIS</u> MD <u>10</u> | |
| CITY (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> | | LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural give location) <u>82 MARKET ST</u> | | HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOMEWOOD CONVALESCENT HOME</u> | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>MARY</u> (Middle) <u>ANN</u> (Last) <u>BOUCHER</u> | | | | 8 - 14 19 55 | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u> | | 8. DATE OF BIRTH <u>11-10-1864</u> | |
| 9. AGE last birthday <u>90</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH BOUCHER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY C. JOHNSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>✓</u> | | 17. INFORMANT & ADDRESS <u>John Boucher</u> (2) | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18b. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u> | | | | 18c. MEDICAL CERTIFICATION | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> | | | | 18d. MEDICAL CERTIFICATION | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | 18e. MEDICAL CERTIFICATION | | | |
| 18f. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | 18g. MEDICAL CERTIFICATION | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | 21g. HOW DID INJURY OCCUR? | | 21h. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>January 19 55</u> to <u>8/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/14</u> , 19 <u>55</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Edward L. Beck</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>4 Southgate Ave Annapolis</u> | | | |
| DATE SIGNED <u>8/15/55</u> | | | | DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>8-17-55</u> | | <u>St Marys</u> | | <u>Annapolis Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Aug 16, 1955</u> | | <u>J. O. O'Connell</u> | | <u>John W. Vaylons</u> | | <u>Annapolis Md</u> | |

BUREAU V. S.

AUG 17 1955

RECEIVED
MAY 17 1955

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07331

7357 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Charles</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Millersville</u> | | <u>2 months.</u> | | TOWN <u>Newport</u> | | <u>08X-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u> | | | | STREET ADDRESS (If rural give location) <u>✓</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>John</u> (Middle) <u>Bowling</u> (Last) | | | | (Month) <u>Aug.</u> (Day) <u>21st.</u> (Year) <u>19 55</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | | 8. DATE OF BIRTH <u>March 1897</u> | |
| 9. AGE last birthday <u>58</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Months | | Days | | Hours | | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Washington B. Bowling</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Higgs</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Sann's Nursing Home Records.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 260X IMMEDIATE CAUSE (A) <u>Diabetes Millitus</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Over 3 1/2 Months</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Paralysis Agitans</u> | | | | | | <u>Over 3 1/2 months</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>6/13/55</u> , 19 <u>55</u> , to <u>8/21/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/19/55</u> , 19 <u>55</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Christian K. Paubert</u> | | | | DATE SIGNED <u>8/21/55</u> | | | |
| M.D. <u>Glen Burnie, Md.</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>8-22-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Dentsville Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Dentsville Md</u> | |
| 24. REC'D BY REGISTRAR <u>8/22/55</u> | | REGISTRAR'S SIGNATURE <u>Julia H. Boney Joyce</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt + Ryan, Waldorf, Md</u> | | | |

05331

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Occupation

7. Cause of death

8. Date of death

9. Time of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of witness

14. Signature of witness

15. Date of registration

16. Time of registration

17. Place of registration

18. Signature of registrar

19. Date of registration

20. Time of registration

21. Place of registration

22. Signature of registrar

23. Date of registration

24. Time of registration

25. Place of registration

26. Signature of registrar

27. Date of registration

28. Time of registration

29. Place of registration

30. Signature of registrar

31. Date of registration

32. Time of registration

33. Place of registration

34. Signature of registrar

35. Date of registration

36. Time of registration

37. Place of registration

38. Signature of registrar

BUREAU V. S.

AUG 24 1955

RECEIVED

20070427

7337

MARYLAND STATE DEPARTMENT OF HEALTH

07332

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

Item 9, Film G187 10-14-55 et

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH-
COUNTY A A MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE MD COUNTY A A | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN ANNAPOLIS | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN ANNAPOLIS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 8 MARYLAND AVE. | | STREET ADDRESS (If rural, give location)
8 MARYLAND AVE. | |
| 3. NAME OF DECEASED
(First) BERTHA (Middle) (Last) BRADLEY | | 4. DATE OF DEATH
(Month) 8 (Day) 31 (Year) 1955 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH
July 29-1878 77 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Texas |
| 13. FATHER'S NAME
Bartley Blueclard Bradley | | 14. MOTHER'S MAIDEN NAME
Adeline Elizabeth Newman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT AND ADDRESS
Frank V. Rigler 270 King Leo St. Annapolis, MD. | |

18. MEDICAL CERTIFICATION

| | | |
|--|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
450.0
Immediate cause Chloroform poisoning | | INTERVAL BETWEEN ONSET AND DEATH |
| (a) Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last | | |
| (c) | | |

| | |
|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | |
|---|--|

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|---|

| | | | | |
|--|--|-----------------------|----------|---------|
| 21. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour)
OF INJURY | INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

| | | |
|--|---|---|
| SIGNATURE
[Signature] | (Degree or title) | DATE SIGNED
8/31/55 |
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF
8/31/55 | NAME OF CEMETERY OR CREMATORY
St. Lincoln |
| DATE REC'D BY LOCAL REG.
Sept. 1, 1955 | REGISTERING SIGNATURE
[Signature] | 24. FUNERAL DIRECTOR
John M. Taylor, Son |
| | | ADDRESS
Annapolis Md. |

VS. A15A

MARCH RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 2 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7358
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07333
Reg. Dist. No. 23

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>X TOWN RURAL</u> | | LENGTH OF STAY (in this place)
— | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3V01-4</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Delmont Road Severn, Maryland</u> | | | | STREET ADDRESS (If rural, give location)
<u>2208 Wilkens Ave.</u> ✓ | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
<u>WILLIAM H. BRUCHEY</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Aug. 2 19 55</u> | | | |
| 5. SEX:
<u>Male</u> | 6. COLOR OR RACE:
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Single</u> | 8. DATE OF BIRTH:
<u>MAY 7, 1936</u> | | 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>19 yrs.</u> Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
<u>Brucheyman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY:
<u>Montgomery Ward & Co.</u> | | 11. BIRTHPLACE (State or foreign country):
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME:
<u>WILLIAM D. BRUCHEY</u> | | | | 14. MOTHER'S MAIDEN NAME:
<u>CATHERINE A. CHRONISTER</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
<u>NO</u> | | 16. SOCIAL SECURITY No.:
<u>212-34-1165</u> | | 17. INFORMANT & ADDRESS:
<u>CATHERINE BRUCHEY 2208 WILKENS AVE</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>981X</u>
Immediate cause (a) <u>Gunshot wound of chest with bilateral massive</u>
<u>-DUE TO hemothorax and gunshot injury of heart</u> | | | | | | | |
| Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>DUE TO</u> | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)
<u>road</u> | | 21c. (City or town) (County) (State)
<u>Severn Anne Arundel Md.</u> | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8/2/55 12:10 A.M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR?
<u>Shot while stealing gasoline</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
SIGNATURE <u>Paul J. Men</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 2, 1955</u>
M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify):
<u>BURIAL</u> | | DATE THEREOF
<u>8-5-55</u> | | NAME OF CEMETERY OR CREMATORY
<u>NEW CATHEDRAL</u> | | LOCATION (City, town, or county) (State)
<u>BALTIMORE, Md.</u> | |
| DATE RECD BY LOCAL REG.
<u>8-3-55</u> | | REGISTRAR'S SIGNATURE
<u>A. W. H. [Signature]</u> | | 24. FUNERAL DIRECTOR
<u>George L. Schwalb</u> | | ADDRESS
<u>2101 Frederick Ave Balto., Md.</u> | |

01533

01533

UNITED STATES DEPARTMENT OF THE INTERIOR

Geological Survey

Washington

June 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully, your obedient servant,

Very truly yours,

John W. Powell

Chief of the Geological Survey

Enclosed for you are two copies of a report on the geology of the

vicinity of the town of...

I am, Sir, very respectfully, your obedient servant,

Very truly yours,

John W. Powell

Chief of the Geological Survey

I am, Sir, very respectfully, your obedient servant,

Very truly yours,

John W. Powell

Chief of the Geological Survey

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07335

7328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|------------------|---|-----------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis</u> | | | | TOWN <u>Annapolis</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 00 <u>7 N. Cherrygrove Ave</u> | | | | <u>7 N. Cherrygrove Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>JOSPHINE M CALLAHAN</u> | | | | <u>AUGUST 21, 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Widowed</u> | <u>March 13, 1872</u> | <u>83</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>house wife</u> | | <u>own home</u> | | <u>Havre De Grace, Md.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Unknown</u> | | | | <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| (If Yes, give war or dates of service) | | <u>none</u> | | <u>Mrs J. Bernard Vallandingham, same as 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardio Vascular Disease - No</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>June 22, 1955</u> , to <u>August 20, 1955</u> , that I last saw the deceased alive on <u>Aug 21, 1955</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Thannie Klamms</u> M.D. | | <u>Aug 24, 1955</u> | | <u>St. Francis Cemetery</u> | | <u>Abington, Maryland</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Burial</u> | | <u>Aug 24, 1955</u> | | <u>HOPPING FUNERAL HOME</u> | | <u>ANNAPOLIS, MD.</u> | |
| DATE <u>Aug. 23, 55</u> | | | | | | | |

07322

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

78-1
CERTIFICATE OF DEATH

No. 1, 1935, Vol. 1

1. DECEASED PERSON'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. DECEASED PERSON'S ADDRESS (Street, city, state, zip)

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH (Immediate cause, underlying cause, contributing cause)

10. PLACE OF DEATH

11. SIGNATURE OF DECEASED PERSON

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF VILLAGE CLERK

22. SIGNATURE OF CITY CLERK

23. SIGNATURE OF STATE CLERK

24. SIGNATURE OF FEDERAL CLERK

25. SIGNATURE OF MARSHAL

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF DISTRICT ATTORNEY

29. SIGNATURE OF COUNTY CLERK

30. SIGNATURE OF TOWNSHIP CLERK

31. SIGNATURE OF VILLAGE CLERK

32. SIGNATURE OF CITY CLERK

33. SIGNATURE OF STATE CLERK

34. SIGNATURE OF FEDERAL CLERK

35. SIGNATURE OF MARSHAL

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CORONER

38. SIGNATURE OF DISTRICT ATTORNEY

39. SIGNATURE OF COUNTY CLERK

40. SIGNATURE OF TOWNSHIP CLERK

41. SIGNATURE OF VILLAGE CLERK

42. SIGNATURE OF CITY CLERK

43. SIGNATURE OF STATE CLERK

44. SIGNATURE OF FEDERAL CLERK

45. SIGNATURE OF MARSHAL

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CORONER

48. SIGNATURE OF DISTRICT ATTORNEY

49. SIGNATURE OF COUNTY CLERK

50. SIGNATURE OF TOWNSHIP CLERK

51. SIGNATURE OF VILLAGE CLERK

52. SIGNATURE OF CITY CLERK

53. SIGNATURE OF STATE CLERK

54. SIGNATURE OF FEDERAL CLERK

55. SIGNATURE OF MARSHAL

56. SIGNATURE OF SHERIFF

57. SIGNATURE OF CORONER

58. SIGNATURE OF DISTRICT ATTORNEY

59. SIGNATURE OF COUNTY CLERK

60. SIGNATURE OF TOWNSHIP CLERK

61. SIGNATURE OF VILLAGE CLERK

62. SIGNATURE OF CITY CLERK

63. SIGNATURE OF STATE CLERK

64. SIGNATURE OF FEDERAL CLERK

65. SIGNATURE OF MARSHAL

66. SIGNATURE OF SHERIFF

67. SIGNATURE OF CORONER

68. SIGNATURE OF DISTRICT ATTORNEY

69. SIGNATURE OF COUNTY CLERK

70. SIGNATURE OF TOWNSHIP CLERK

71. SIGNATURE OF VILLAGE CLERK

72. SIGNATURE OF CITY CLERK

73. SIGNATURE OF STATE CLERK

74. SIGNATURE OF FEDERAL CLERK

75. SIGNATURE OF MARSHAL

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF CORONER

78. SIGNATURE OF DISTRICT ATTORNEY

79. SIGNATURE OF COUNTY CLERK

80. SIGNATURE OF TOWNSHIP CLERK

81. SIGNATURE OF VILLAGE CLERK

82. SIGNATURE OF CITY CLERK

83. SIGNATURE OF STATE CLERK

84. SIGNATURE OF FEDERAL CLERK

85. SIGNATURE OF MARSHAL

86. SIGNATURE OF SHERIFF

87. SIGNATURE OF CORONER

88. SIGNATURE OF DISTRICT ATTORNEY

89. SIGNATURE OF COUNTY CLERK

90. SIGNATURE OF TOWNSHIP CLERK

91. SIGNATURE OF VILLAGE CLERK

92. SIGNATURE OF CITY CLERK

93. SIGNATURE OF STATE CLERK

94. SIGNATURE OF FEDERAL CLERK

95. SIGNATURE OF MARSHAL

96. SIGNATURE OF SHERIFF

97. SIGNATURE OF CORONER

98. SIGNATURE OF DISTRICT ATTORNEY

99. SIGNATURE OF COUNTY CLERK

100. SIGNATURE OF TOWNSHIP CLERK

101. SIGNATURE OF VILLAGE CLERK

102. SIGNATURE OF CITY CLERK

103. SIGNATURE OF STATE CLERK

104. SIGNATURE OF FEDERAL CLERK

105. SIGNATURE OF MARSHAL

106. SIGNATURE OF SHERIFF

107. SIGNATURE OF CORONER

108. SIGNATURE OF DISTRICT ATTORNEY

109. SIGNATURE OF COUNTY CLERK

110. SIGNATURE OF TOWNSHIP CLERK

111. SIGNATURE OF VILLAGE CLERK

112. SIGNATURE OF CITY CLERK

113. SIGNATURE OF STATE CLERK

114. SIGNATURE OF FEDERAL CLERK

115. SIGNATURE OF MARSHAL

116. SIGNATURE OF SHERIFF

117. SIGNATURE OF CORONER

118. SIGNATURE OF DISTRICT ATTORNEY

119. SIGNATURE OF COUNTY CLERK

120. SIGNATURE OF TOWNSHIP CLERK

121. SIGNATURE OF VILLAGE CLERK

122. SIGNATURE OF CITY CLERK

123. SIGNATURE OF STATE CLERK

124. SIGNATURE OF FEDERAL CLERK

125. SIGNATURE OF MARSHAL

126. SIGNATURE OF SHERIFF

127. SIGNATURE OF CORONER

128. SIGNATURE OF DISTRICT ATTORNEY

BUREAU V. 2

AUG 25 1935

RECEIVED

MARYLAND

7359

07336

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------|---|---|
| 1. PLACE OF DEATH-
COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE <u>MD.</u> COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Severna Park</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Rural. Severna Park</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>—</u> | | STREET ADDRESS (If rural, give location)
<u>Cor. Old Line of Old Belvidere Rd. Ritchie Highway</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Anna Fitzgerald CAUFFMAN.</u> | | 4. DATE OF DEATH <u>Aug. 2</u> 19 <u>65</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>14 Dec 1905</u> 49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Waitress & Housewife - Restaurant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 13. FATHER'S NAME <u>Sylvester Staylor</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret O'Neil</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Severna</u>
<u>Husband - LeRoy Cauffman, Park</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |

| | | | |
|---|---|--|----------------------------------|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause <u>420.1</u> | | (a) <u>MYOCARDIAL INFARCTION (Multiple)</u> | <u>5 yrs.</u>
<u>10 yrs.</u> |
| Antecedent cause(s) <u>Coronary Sclerosis</u> | | (b) <u>HYPertensive Cardio-Vascular</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Disease</u> | | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from APRIL, 1955 to 2 Aug, 1965, that I last saw the deceasedalive on 1 Aug., 1955, and that death occurred at 4:45 P.m., from the causes and on the date stated above.

| | | | |
|---|---|---|--|
| SIGNATURE <u>Robert R. Halpin</u> | (Degree or title) | ADDRESS <u>Severna Park Md.</u> | DATE SIGNED <u>2 Aug. 1965</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Aug 5/1965</u> | <u>Belair Hill</u> | <u>U.S.A.</u> |
| DATE RECD BY LOCAL REG. <u>P. J. - 35</u> | REGISTRAR'S SIGNATURE <u>P. J. - 35</u> | 24. FUNERAL DIRECTOR <u>C. Ballard & Sons</u> | ADDRESS <u>1400 18th Ave</u> |

MARGIN RESERVED FOR BINDING

13838

13838

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637
U.S.A.

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637
U.S.A.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Cassedy 7360

CERTIFICATE OF DEATH

Reg. Dist. No.

0733721

| | | | |
|--|--------------------------------|--|---------------------------|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY A A | MARYLAND | STATE Maryland | COUNTY Balto. |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR | |
| X TOWN near Gibson Island | | TOWN Baltimore 12 | 03X-2 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 00 Rocky Beach Farm | | 6416 Pinehurst Road | ✓ |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) | |
| Thomas S. Cassedy | | OF DEATH: August 1, 1955 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH: |
| Male | White | Married | September 21, 1904 |
| 9. AGE last birthday | | 10. CITIZEN OF WHAT COUNTRY? | |
| 50 yrs. Months Days Hours Min. | | U. S. A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | |
| Engr. | | Consulting | |
| 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Gloversville, New York | | U. S. A. | |
| 13. FATHER'S NAME: | | 14. MOTHER'S MAIDEN NAME: | |
| Edward K. Cassedy | | Capitola Bowen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Yes W.W. 2 | | | |
| 17. INFORMANT & ADDRESS: | | | |
| Mrs. Alice C. Cassedy, 6416 Pinehurst Road | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE | | 1955 | |
| ANTECEDENT CAUSE (S) | | 1954 | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | 1954 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| | | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I hereby certify that I attended the deceased from June, 1957 , to Aug 1, 1955 , that I last saw the deceased alive on Aug 1, 1955 , and that death occurred at 12:09 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE | | DATE SIGNED | |
| Ag 1 | | 12.09 P.M. | |
| M. D. | | ADDRESS | |
| B. R. Bishop | | Baltimore, Md. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | |
| Burial | | August 3, 1955 | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Moreland Memorial Cemetery | | 703 Sheridan Rd. Baltimore, Md. | |
| DATE REC'D BY LOCAL REGISTRAR | | 24. FUNERAL DIRECTOR | |
| Aug 2-55 | | Wm. J. Tickner & Sons, Balto. 17, Md. | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7329

CERTIFICATE OF DEATH

07338

Reg. Dist. No.

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|--|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNA POLIS</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>ANNA POLIS</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| OR TOWN <u>ANNA POLIS</u> | | | | OR TOWN <u>ANNA POLIS</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>63 A.A. General Hosp.</u> | | | | <u>1990 West Street</u> | | 1 | |
| 3. NAME OF DECEASED
(Type or Print) (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>William Henry Colbert Jr.</u> | | | | <u>8 7 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>Male</u> | <u>Colored</u> | | <u>4-1-1955</u> | <u>4</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | <u>---</u> | | <u>MARYLAND</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>William Colbert</u> | | | | <u>Mabel Brown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>---</u> | | <u>William Colbert Jr., 1990 West St</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 570.5 IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>8-7-55</u> , 19 <u>55</u> , to <u>8-7-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-7-55</u> , 19 <u>55</u> , and that death occurred at <u>7</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M.D. | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>W. T. Lee</u> | | <u>W. T. Lee</u> | | <u>62 Cathedral St</u> | | <u>8-7-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>8-9-55</u> | | <u>Nope Chapel</u> | | <u>Edgewater, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Aug 9, 1955</u> | | <u>Wm. J. French</u> | | <u>William Reese II</u> | | <u>108 W. Wash. St</u> | |
| | | | | | | <u>ANNA POLIS, Md.</u> | |

4045267367

11/11/11

2-1-1-2
2-1-1-1

2-1-1-2

2-1-17

BUREAU V. S.

SECRET

Chapel Road, M9

78 42911 W 201 H 9000/11111 W

Miss E. A. Williams

1881-1882

Robertson, John

William C. Merrill

075

What is Colored

William Henry Colburn Jr.

9024 14-1540-5 AA

2. 1. 59 4 11 11

USA

21/1/1944

C. H. H. [illegible]

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07339

7330

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|------------------|--|----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis</u> | | | | TOWN <u>Annapolis</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 63 <u>Anne Arundel General Hospital</u> | | | | 76 <u>East Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) (Middle) (Last) | | | | | | | |
| <u>NATHAN</u> <u>COOPER</u> | | | | <u>August 30</u> , 19 <u>55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>March 8, 1890</u> | <u>65</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Tailor</u> | | <u>Custom tailor shop</u> | | <u>Poland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Morris Cooper</u> | | | | <u>Sadie Diamond</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Mrs Anna Cooper- same as # 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 581.0 IMMEDIATE CAUSE (A) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Maurice Klamans</u> M.D. | | <u>September 1, 55</u> | | <u>Montiflore Cemetery</u> | | <u>Philadelphia, Pa.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Removal</u> | | <u>Sept. 1, 1955</u> | | <u>HOPPING FUNERAL HOME</u> | | <u>ANNAPOLIS, MD.</u> | |

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the health officer of the city or county in which the death occurred. It should be filled out for all deaths, whether the cause of death is natural, accidental, or suicidal, and whether the death is reported to the health officer or not. It should be filled out for all deaths, whether the death is reported to the health officer or not. It should be filled out for all deaths, whether the death is reported to the health officer or not.

CERTIFICATE OF DEATH

1580

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

05880

Back Cover 1580

2. PHYSICIAN'S SIGNATURE AND LICENSE

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. SEX

7. AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

BUREAU V. 2

SEP 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7361

CERTIFICATE OF DEATH

07340

Reg. Dist. No. 24

| | | | | | | | |
|--|------------------------------|---|---|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| OR and give nearest town | | LENGTH OF STAY (In this place) | | OR TOWN <u>Glen Burnie</u> | | OR TOWN <u>Glen Burnie</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | | 120 Marie Ave., N.E. | | 120 Marie Ave., N.E. | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>Rheba</u> | | (Middle) <u>M.</u> | | (Last) <u>Coplin</u> | | <u>August 5, 1955</u> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>Oct-13, 1892</u> | <u>62</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housework</u> | | <u>Own Home</u> | | <u>Baltimore Maryland</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Harvey</u> | | | | <u>Mamie Brown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>Aaron Coplin 120 Marie Ave. Glen Burnie, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> | | | | | | <u>3 days</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) | | | | | | <u>years</u> | |
| STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| <input type="checkbox"/> | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | <input type="checkbox"/> <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from 3-1953, to 8-1955, that I last saw the deceased alive on 8-4-55, 1955, and that death occurred at 5 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M.D. | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>C. MacDonald M.D.</u> | | <u>Islen Burnie Md.</u> | | <u>8-5-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | |
| <u>Burial</u> | <u>August 8, 1955</u> | <u>Baltimore National Cem.</u> | | <u>Baltimore</u> | | <u>Maryland</u> | |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | |
| <u>Aug. 6, 1955</u> | <u>L. J. DeAlba</u> | | <u>Richard V. Brighton</u> | | <u>Glen Burnie Md.</u> | | |

BUREAU V. S.

AUG 8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7331

07341

Reg. Dist.

No. 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY A. A. County | | MARYLAND | | STATE Maryland COUNTY A.A. | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| TOWN Annapolis | | Transient | | TOWN Drury, Maryland | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital | | | | STREET ADDRESS (If rural, give location) Wayson's Corner. | | | |
| 3. NAME OF DECEASED:
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Cleve (Middle) (Last) CRINER | | | | 8 26 1955 | | | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH: | |
| Male | | White | | Married | | -- | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| Laborer | | Sawmill | | Virginia | | U.S.A. | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| Clarence Criner | | | | Alice Sheldon | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| Yes W.W.II. | | | | -- | | Mrs. Pauline O'Neal
West River, Md. | |

| | | | | | | | | | |
|--|--|---|--|--|--|--------------------------------------|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 9103
Immediate cause | | | | | | (a) breathless shock - due to | | 2 hrs. | |
| Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | | | | | (b) Internal injuries | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) | | (County) | | (State) | |
| | | | | A & Co | | | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 8 26 55 1 P.M. | | | | Dug fell on subject | | | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | |
| | | | | M. D. 8/26/55 | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | |
| Burial Removal | | Aug. 27, 1955 | | Vaughan-Guynn Funeral Home | | Galax, Va. | | | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | | | |
| Aug. 30, 1955 | | Wm. F. French | | Ritchie Bros. Funeral Home, | | Upper Marlboro, Md. | | | |

1955

1955

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

TO: [Illegible]

FROM: [Illegible]

DATE: [Illegible]

BUREAU V. 5

SEP 1 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7332

CERTIFICATE OF DEATH

07342

Reg. Dist. No. 21

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Anne Arundel</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Anne Arundel</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| 10 TOWN <i>Annapolis</i> | | TOWN <i>Annapolis</i> | 10 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General</i> | | STREET ADDRESS (If rural give location) <i>111 Academy St.</i> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <i>Caroline Davis</i> | | <i>Aug. 1, 1955</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i> | 8. DATE OF BIRTH <i>March 29, 1874</i> |
| 9. AGE last birthday <i>81</i> yrs. | | 10. UNDER 1 YEAR <i>1</i> Months <i>1</i> Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Arnold, Md.</i> |
| 13. FATHER'S NAME <i>Edward Spriggs</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Frances</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>110</i> | |
| 17. INFORMANT & ADDRESS <i>Mrs. J. J. Stetile #2</i> | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 332X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i> | | 7 days. | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral & general arteriosclerosis</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Small Arteriosclerosis</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>M.</i> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>7/14</i> , 19 <i>55</i> , to <i>8/1</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/1</i> , 19 <i>55</i> , and that death occurred at <i>5:45</i> P.M. from the causes and on the date stated above. | | | |
| SIGNATURE <i>Mannie Klamans</i> M.D. | | ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | DATE THEREOF <i>8-3-1955</i> | NAME OF CEMETERY OR CREMATORY <i>Asbury Methodist</i> | LOCATION (City, town, or county) (State) <i>Arnold Md.</i> |
| 24. REC'D BY REGISTRAR <i>John M. Taylor & Sons</i> | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS |
| DATE <i>8-3-1955</i> | | | |

13813

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DEATH CERTIFICATE

REG. DIST. NO.

1. NAME OF DECEASED

MARYLAND

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF JAILER

20. SIGNATURE OF WARDEN

21. SIGNATURE OF CHIEF OF POLICE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF COUNTY COMMISSIONER

25. SIGNATURE OF COUNTY SHERIFF

26. SIGNATURE OF COUNTY JAILER

27. SIGNATURE OF COUNTY WARDEN

28. SIGNATURE OF COUNTY CHIEF OF POLICE

29. SIGNATURE OF COUNTY DISTRICT ATTORNEY

BUREAU V. 2

AUG 4 1955

RECEIVED

1/14 1955

1/14 1955

1/14 1955

1/14 1955

200117171

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08326
 Item 2, File G186 9-15-55 et

7362

CERTIFICATE OF DEATH

Reg. Dist. No.

22

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Anne Arundel</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Anne Arundel</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| X TOWN <u>LAUREL</u> | <u>5 months</u> | TOWN <u>LAUREL, MARYLAND</u> | <u>Wash. D.C.</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS | |
| <u>11 District Training School</u> | | <u>1006 N. ST. N. District Training School</u> | <u>47X3</u> |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE OF DEATH: (Month) (Day) (Year) | |
| <u>Stanley - DEAN</u> | | <u>August 28 1955</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: |
| <u>MALE</u> | <u>NEGRO</u> | <u>Single</u> | <u>July 3, 1953</u> |
| 9. AGE last birthday | 10. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
| <u>2 yrs.</u> | <u>NONE</u> | <u>WASHINGTON, D.C.</u> | <u>U.S.A.</u> |
| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: | | |
| <u>NATHANIEL TAYLOR</u> | <u>GEORGIA MAE DEAN</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT & ADDRESS: | |
| <u>No</u> | <u>None</u> | <u>District Training School's files</u> | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>INANITION</u> | | | <u>20 days</u> |
| ANTECEDENT CAUSE (B) <u>Intestinal Toxemia</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| <u>HYDROCEPHALIC Idiot</u> | | | |
| 19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <u>0</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) | |
| | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug. 8, 1955</u> , to <u>Aug. 28, 1955</u> that I last saw the deceased alive on <u>Aug. 28, 1955</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE | | ADDRESS | DATE SIGNED |
| <u>Margaret Wong Mola</u> | | <u>M. D. District Training School</u> | <u>8-28-55</u> |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Removal</u> | <u>Aug 31-55</u> | <u>District Training School</u> | <u>Laurel, Md.</u> |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
| <u>Aug 28-55</u> | <u>Elaine Haslup</u> | <u>Milton Melvin</u> | <u>Washington</u> |

BUREAU V. S.

SEP 13 1955

RECEIVED

MARYLAND

7363

07343

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
COUNTY <u>U. D. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>SA-2nd Co.</u> COUNTY <u>U. D. Co.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Edgewater P.D.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Marley Heights</u> | |
| TOWN <u>Edgewater P.D.</u> | | TOWN <u>Marley Heights</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>None</u> | | STREET ADDRESS
<u>SA-2nd Co - Marley Heights</u> | |
| 3. NAME OF DECEASED
(Type or Print) <u>Elzabeta</u> (First) (Middle) (Last) <u>Dupski</u> | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>Aug-10, 1955</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>4/3/82</u> |
| 9. AGE last birthday
<u>72</u> yrs. | | 10. AGE last birthday
If under 1 year: Months Days Hours Min.
<u>11 8 4</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Nurse</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Austria - Linz</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>Austria</u> | |
| 13. FATHER'S NAME
<u>Stephens Fitz</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY No.
<u>None</u> | |
| 17. INFORMANT AND ADDRESS
<u>Mr. Nicholas J. Dupski, 3940 Brooklyn Avenue</u> | | | |

| | | | | | |
|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1
Immediate cause
(a) <u>Cerebral Thrombosis</u> | | | | <u>Immediate</u> | |
| Antecedent cause(s)
(b) <u>arteriosclerosis - Cardio Vascular Disease</u> | | | | <u>1 yr.</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(c) <u>None</u> | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION
<u>11/7/55</u> | | 19b. MAJOR FINDINGS OF OPERATION
<u>Gall-bladder disease</u> | | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (If home, farm, factory, street, office bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 5/9, 1955, to 8/10/55, that I last saw the deceased alive on 8/10/55, 1955, and that death occurred at 8/10/55 m. from the causes and on the date stated above.

SIGNATURE Albert Anderson M.D. (Degree or title) ADDRESS 45 Scrut. Quinn & Co., Wash. D.C. DATE SIGNED 8/10/55

| | | | |
|---|---|---|---|
| 23. BURIAL REMOVAL (Specify)
<u>Burial</u> | DATE
<u>August 13, 1955</u> | NAME OF CEMETERY OR CREMATORY
<u>Holy Cross Cemetery</u> | LOCATION (City, town, or county) (State)
<u>Brooklyn, Maryland</u> |
| DATE REC'D BY LOCAL REG.
<u>Aug 11, 1955</u> | REGISTRAR'S SIGNATURE
<u>A. W. Hedrick</u> | 24. FUNERAL DIRECTOR
<u>Wm. J. Pickner & Sons, Balt. 17, Md.</u> | |

MARGIN RESERVED FOR BINDING

3

1

I

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within ~~24~~ ⁷² hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

11

8332

CERTIFICATE OF DEATH

22

Item 9, Film G187 9-28-55 et

Reg. Dist. No.

| | | | |
|---|--------------------------------|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Anne Arundel</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Anne Arundel</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| <i>X</i> TOWN <i>Severn</i> | | TOWN <i>Severn</i> | <i>X</i> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Camp Meade Road</i> | | STREET ADDRESS (If rural give location) <i>Camp Meade Road</i> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) <i>Henrietta</i> (Middle) <i>-</i> (Last) <i>Durner</i> | | (Month) <i>8</i> (Day) <i>28</i> (Year) <i>19 55</i> | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| <i>Female</i> | <i>White</i> | <i>Married</i> | <i>Oct. 16, 1877</i> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday |
| <i>Housework</i> | | <i>own Home</i> | <i>87</i> yrs. |
| 10a. FATHER'S NAME | | 11. BIRTHPLACE (State or foreign country) | |
| <i>Basil Griffith</i> | | <i>Anne Arundel Co., Md.</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME | |
| <i>No</i> | | <i>Emily Hawkins</i> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| <i>None</i> | | <i>Mr. Wesley Durner, Severn, Md.</i> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| 332X IMMEDIATE CAUSE (A) <i>CEREBRAL THROMBOSIS</i> | | | <i>1 wk.</i> |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>CEREBRAL ARTERIOSCLEROSIS</i> | | | <i>4 yrs.</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>-</i> | | | <i>-</i> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | <i>-</i> |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| <i>-</i> | | <i>-</i> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| <input type="checkbox"/> | | <i>-</i> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. HOW DID INJURY OCCUR? | |
| <i>-</i> | | <i>-</i> | |
| 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | <i>-</i> | |
| 22. I hereby certify that I attended the deceased from <i>SEPT.</i>, 19 <i>53</i>, to <i>AUG. 28</i>, 19 <i>55</i>, that I last saw the deceased alive on <i>8-27</i>, 19 <i>55</i>, and that death occurred at <i>1:40 A.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE | | DATE SIGNED | |
| <i>Leon C. Perry</i> | | <i>201 B + A Blvd GLEN BURNIE MD. 8-31-55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | NAME OF CEMETERY OR CREMATORY | |
| <i>Burial</i> | | <i>Glen Haven</i> | |
| DATE THEREOF | | LOCATION (City, town, or county) | |
| <i>Sept. 1, 1955</i> | | <i>Glen Burnie, Md.</i> | |
| 24. REGD BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | |
| <i>Sept 7-55</i> | | <i>W. J. Singleton</i> | |
| REGISTRAR'S SIGNATURE | | ADDRESS | |
| <i>Clara Heaslip</i> | | <i>W. J. Singleton, Glen Burnie, Md.</i> | |

CERTIFICATE OF DEATH

2230

A. NAME OF DECEASED

MARYLAND

COUNTY

B. SEX

MALE

AGE

C. DATE OF DEATH

1912

TIME

D. PLACE OF DEATH

HOME

CAUSE OF DEATH

E. PLACE OF BIRTH

MD

EDUCATION

F. OCCUPATION

LABORER

RELIGION

G. MARITAL STATUS

SINGLE

PREVIOUS MARRIAGES

H. DATE OF MARRIAGE

1908

NAME OF SPOUSE

I. NAME OF SPOUSE

JOHN

DATE OF DEATH

J. NAME OF SPOUSE

JOHN

DATE OF DEATH

K. NAME OF SPOUSE

JOHN

DATE OF DEATH

L. NAME OF SPOUSE

JOHN

DATE OF DEATH

M. NAME OF SPOUSE

JOHN

DATE OF DEATH

N. NAME OF SPOUSE

JOHN

DATE OF DEATH

O. NAME OF SPOUSE

JOHN

DATE OF DEATH

P. NAME OF SPOUSE

JOHN

DATE OF DEATH

Q. NAME OF SPOUSE

JOHN

DATE OF DEATH

R. NAME OF SPOUSE

JOHN

DATE OF DEATH

S. NAME OF SPOUSE

JOHN

DATE OF DEATH

T. NAME OF SPOUSE

JOHN

DATE OF DEATH

U. NAME OF SPOUSE

JOHN

DATE OF DEATH

V. NAME OF SPOUSE

JOHN

DATE OF DEATH

W. NAME OF SPOUSE

JOHN

DATE OF DEATH

X. NAME OF SPOUSE

JOHN

DATE OF DEATH

Y. NAME OF SPOUSE

JOHN

DATE OF DEATH

Z. NAME OF SPOUSE

JOHN

DATE OF DEATH

AA. NAME OF SPOUSE

JOHN

DATE OF DEATH

AB. NAME OF SPOUSE

JOHN

DATE OF DEATH

AC. NAME OF SPOUSE

JOHN

DATE OF DEATH

AD. NAME OF SPOUSE

JOHN

DATE OF DEATH

AE. NAME OF SPOUSE

JOHN

DATE OF DEATH

AF. NAME OF SPOUSE

JOHN

DATE OF DEATH

AG. NAME OF SPOUSE

JOHN

DATE OF DEATH

AH. NAME OF SPOUSE

JOHN

DATE OF DEATH

AI. NAME OF SPOUSE

JOHN

DATE OF DEATH

AJ. NAME OF SPOUSE

JOHN

DATE OF DEATH

AK. NAME OF SPOUSE

JOHN

DATE OF DEATH

AL. NAME OF SPOUSE

JOHN

DATE OF DEATH

AM. NAME OF SPOUSE

JOHN

DATE OF DEATH

AN. NAME OF SPOUSE

JOHN

DATE OF DEATH

AO. NAME OF SPOUSE

JOHN

DATE OF DEATH

AP. NAME OF SPOUSE

JOHN

DATE OF DEATH

AQ. NAME OF SPOUSE

JOHN

DATE OF DEATH

AR. NAME OF SPOUSE

JOHN

DATE OF DEATH

AS. NAME OF SPOUSE

JOHN

DATE OF DEATH

AT. NAME OF SPOUSE

JOHN

DATE OF DEATH

AU. NAME OF SPOUSE

JOHN

DATE OF DEATH

AV. NAME OF SPOUSE

JOHN

DATE OF DEATH

AW. NAME OF SPOUSE

JOHN

DATE OF DEATH

AX. NAME OF SPOUSE

JOHN

DATE OF DEATH

AY. NAME OF SPOUSE

JOHN

DATE OF DEATH

AZ. NAME OF SPOUSE

JOHN

DATE OF DEATH

BA. NAME OF SPOUSE

JOHN

DATE OF DEATH

BB. NAME OF SPOUSE

JOHN

DATE OF DEATH

BC. NAME OF SPOUSE

JOHN

DATE OF DEATH

BD. NAME OF SPOUSE

JOHN

DATE OF DEATH

BUREAU V. 1

RECEIVED
SEP 20 1912

John [illegible]

7364

07344

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45

Reg. Dist.

| | | | | | |
|---|------------------------------------|---|--|---------------------------|----------------------------------|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY | Anne Arundel | | STATE | D. C. COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | |
| TOWN | Fort Meade | | TOWN | Washington | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Fort Meade | | STREET ADDRESS | (If rural, give location) | |
| | | | 6308 Livingston Road S. E. | | |
| 3. NAME OF DECEASED: | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) (Day) (Year) |
| (Type or Print) | DOROTHY | WEESE | EDELEN | 8 | 15 19 55 |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Female | White | Married | August 6, 1930 | 25 yrs. | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | | | |
| Waitress | Resturant | White Sulphur Springs, W. Va. | | | |
| 13. FATHER'S NAME: | | | 14. MOTHER'S MAIDEN NAME: | | |
| Henry Weese | | | Josephine Mullens | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | | 17. INFORMANT & ADDRESS: | | |
| No | | | Harvey M. Weese 2809 Page Drive Baltimore 22 Md. | | |

| | | | | |
|---|---|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | |
| Immediate cause (a)..... Depressed skull fracture, left frontal and
DUE TO
Antecedent cause(s) (b)..... sphenoid bones
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c)..... | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) | (County) | (State) |
| | Street | Fort Meade | Anne Arundel | Maryland |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | | |
| 8/15/55 2:45 P.M. | | Auto-auto collision | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | |
| SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 8/16/55 | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) | |
| Removal | Aug. 18, 1955 | Watco Cemetery | White Sulphur Springs W. Va. | |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | |
| 12-35 | | | Wm Cook - Blight, Inc. 6009 Harford Road | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNITED STATES OF AMERICA
 DEPARTMENT OF THE INTERIOR
 BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
 RIVER MANAGEMENT SECTION
 WATERSHED MANAGEMENT UNIT

WATER RESOURCES DIVISION
 RIVER MANAGEMENT SECTION
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WATER RESOURCES DIVISION
 RIVER MANAGEMENT SECTION
 WATERSHED MANAGEMENT UNIT

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7365

CERTIFICATE OF DEATH

08242

Item 9, FilmG186 9-19-55 et

Reg. Dist. No. 27

| | | | | | | | |
|---|--------------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE D.C. | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN Fort George G. Meade | | 15 days | | TOWN Washington | | 16x.2 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital | | | | STREET ADDRESS (If rural give location) 6308 Livingston Rd.S.E. | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) WILMER R. EDELEN | | | | 4. DATE OF DEATH (Month) (Day) (Year) August 30 19 55 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH December 23, 1912 | | 9. AGE last birthday 42 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Edelen | | | | 14. MOTHER'S MAIDEN NAME Georgie Wilkinson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT & ADDRESS Mrs. Joseph Duley, same as block #2. | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 816x IMMEDIATE CAUSE (A) Contusion of Brain | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 days | |
| ANTECEDENT CAUSE(S) DUE TO (B) multiple injuries due to auto accident | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) street | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Annapolis Rd, Ft GG Meade A.A. Md. | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 2:30 PM Aug 15 55 | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Head on collision | | | |
| 22. I hereby certify that I attended the deceased from August 15 19 55 , to August 31, 19 55 , that I last saw the deceased alive on August 31, 19 55 , and that death occurred at 2050 PM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE HERBERT L. NEEDLEMAN, 1ST LT MC | | | | ADDRESS (Street, city, town, state) Fort G.G. Meade, Maryland August 30, 1955 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried | | DATE THEREOF 9-2-55 | | NAME OF CEMETERY OR CREMATORY Trinity Cemetery | | LOCATION (City, town, or county) (State) Upper Marlboro, Md. | |
| 24. REC'D BY REGISTRAR 30 Aug 55 | | W.L.SAYLOR, 1/Lt MSC | | 25. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros, Upper Marlboro, Md. | | | |

08845

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1985

Form 10-1-10-11

1. PLACE OF BIRTH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE

11. DATE

12. SIGNATURE

13. DATE

14. SIGNATURE

15. DATE

16. SIGNATURE

17. DATE

BUREAU V. S.

SEP 6 1985

RECEIVED

W. J. [Signature]

Director, State Department of Health, Baltimore, Md.

10-1-10-11

08333

MARYLAND

7366

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 22

| | | | |
|--|---------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH-
COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE <u>Maryland</u> COUNTY <u>A. A.</u> | |
| X CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Barbersville</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Barbersville</u> X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location)
<u>1</u> | |
| 3. NAME OF DECEASED (Type or Print)
(First) <u>Mollie</u> (Middle) <u>Virginia</u> (Last) <u>Gorman</u> | | 4. DATE OF DEATH (Month) <u>August</u> (Day) <u>17</u> (Year) <u>1955</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>June 6, 1900</u> |
| 9. AGE last birthday <u>55</u> yrs. | | 10. AGE last birthday If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Edenton Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Thomas Smithson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Jane Beckett</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY No.
<u>None</u> | |
| 17. INFORMANT AND ADDRESS
<u>Mary C. Eaton, Baltimore 24, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 4-20.1
Immediate cause (a) <u>Acute Coronary Occlusion</u> | | | |
| Antecedent cause(s) (b) <u>Decompensation, Cardiac</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis, advanced.</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u> | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. MAJOR FINDINGS OF OPERATION
<u>None</u> | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u> | | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>None</u> | |
| (CITY OR TOWN) <u>None</u> (COUNTY) <u>None</u> (STATE) <u>None</u> | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> | | INJURY OCCURRED While at <u>None</u> Work <input checked="" type="checkbox"/> At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR?
<u>None</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>3/18</u> , 19 <u>55</u> , to <u>8/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/17/55</u> , 19 <u>55</u> , and that death occurred at <u>5:15 a.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>R. L. Eubank</u> (Degree or title) <u>M.D.</u> | | ADDRESS <u>Laurel, Md.</u> DATE SIGNED <u>8/17/55</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE <u>Aug 19 1955</u> NAME OF CEMETERY OR CREMATORY <u>Any Hill Cemetery</u> LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u> | |
| DATE REC'D BY LOCAL REG. <u>Aug 19-55</u> | | RECEIVAR'S SIGNATURE <u>Olana Haslup</u> 24. FUNERAL DIRECTOR <u>Dr. W. H. Donaldson, Laurel, Md.</u> ADDRESS <u>Laurel, Md.</u> | |

COPIES RESERVED FOR BINDING

RECEIVED

SEP 13 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7367

CERTIFICATE OF DEATH

07345

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>AA</u>
MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Riva</u> | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Riva</u> | |
| TOWN <u>Riva</u> | | LENGTH OF STAY (in this place)
<u>1 year</u> | | TOWN <u>Riva</u> | | TOWN <u>Riva</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Sylvan Shores</u> | | | | STREET ADDRESS (If rural give location)
<u>Sylvan Shores</u> | | | |
| 3. NAME OF DECEASED
(Type or Print)
<u>George E. Gray</u> | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>Aug 4th 1955</u> | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | | 8. DATE OF BIRTH
<u>Aug 7th 1889</u> | |
| 9. AGE last birthday
<u>67</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Rep. Supervisor Merchandise</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore, Maryland</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Gray</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Annie</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>215-05-3648A</u> | | | | 17. INFORMANT & ADDRESS
<u>Edna H. Gray, Riva, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) <u>coronary heart disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 years</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary occlusion</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8-4-55</u> , to <u>8-4-55</u> , that I last saw the deceased alive on <u>8-4-55</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Edith Roeller</u> | | | | DATE SIGNED
<u>8-4-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | | 24. REC'D BY REGISTRAR
<u>Louis J. De Allegre</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Cook, Inc.</u> | | | | 26. ADDRESS
<u>1217 E. Paul St.</u> | | | |

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 2, 11, 12, 13, 14 Film 185 8-29-55 et

7368

CERTIFICATE OF DEATH

0734626

Reg. Dist. No. 242

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>D. C.</u> | | COUNTY <u>--</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| X TOWN <u>Columbia Beach</u> | | | | TOWN <u>Washington</u> | | 47X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| | | | | 1708 2nd St., N.W. ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Justine</u> (Middle) (Last) <u>Greene</u> | | | | (Month) (Day) (Year) | | | |
| | | | | 8th 20th 1955 | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>C</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| | | | | | | Sept 21 - 1891 | |
| | | | | 9. AGE last birthday | | 63 yrs. | |
| | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| | | | | Months Days | | Hours Min. | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | | Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Wilkes | | | | Sadie Thompson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| | | | | | | Husband
Perman Greene - 1708 - 2nd St N.W. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) | | | | Probable Coronary Occlusion | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | History of hypertension | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | did not attend the deceased during life | | | |
| 22. I hereby certify that I attended the deceased from 19 to 19 that I last saw the deceased alive on 19 and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>F. D. Hendricks</u> Acting Medical Examiner (State, city, town, state) DATE SIGNED <u>20 Aug 55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Burial | | 8-23-55 | | Lincoln Memorial | | Suitland Md. | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| 8-21-55 | | <u>George F. Campbell</u> | | <u>Robert McShine</u> | | 1820 9th St. N.W. | |
| DATE | | | | | | | |

1955

CERTIFICATE OF DEATH

1955

1. DECEASED'S NAME (Last, first, middle initial)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. MARRIAGE

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF GRAND JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CORONER

26. SIGNATURE OF JURY

27. SIGNATURE OF GRAND JURY

28. SIGNATURE OF COURT

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CORONER

32. SIGNATURE OF JURY

33. SIGNATURE OF GRAND JURY

34. SIGNATURE OF COURT

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CORONER

38. SIGNATURE OF JURY

39. SIGNATURE OF GRAND JURY

40. SIGNATURE OF COURT

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CORONER

44. SIGNATURE OF JURY

45. SIGNATURE OF GRAND JURY

46. SIGNATURE OF COURT

47. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF CORONER

50. SIGNATURE OF JURY

51. SIGNATURE OF GRAND JURY

52. SIGNATURE OF COURT

53. SIGNATURE OF JUDGE

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF CORONER

56. SIGNATURE OF JURY

57. SIGNATURE OF GRAND JURY

58. SIGNATURE OF COURT

59. SIGNATURE OF JUDGE

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF CORONER

62. SIGNATURE OF JURY

63. SIGNATURE OF GRAND JURY

64. SIGNATURE OF COURT

65. SIGNATURE OF JUDGE

66. SIGNATURE OF SHERIFF

67. SIGNATURE OF CORONER

68. SIGNATURE OF JURY

69. SIGNATURE OF GRAND JURY

70. SIGNATURE OF COURT

71. SIGNATURE OF JUDGE

72. SIGNATURE OF SHERIFF

73. SIGNATURE OF CORONER

74. SIGNATURE OF JURY

75. SIGNATURE OF GRAND JURY

76. SIGNATURE OF COURT

77. SIGNATURE OF JUDGE

78. SIGNATURE OF SHERIFF

79. SIGNATURE OF CORONER

80. SIGNATURE OF JURY

81. SIGNATURE OF GRAND JURY

82. SIGNATURE OF COURT

83. SIGNATURE OF JUDGE

84. SIGNATURE OF SHERIFF

85. SIGNATURE OF CORONER

86. SIGNATURE OF JURY

BUREAU V. A.

AUG 26 1955

RECEIVED

MASSACHUSETTS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07347

7369

CERTIFICATE OF DEATH

Reg. Dist. No. 27

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>W. Va.</u> | | COUNTY <u>Kanawha</u> | |
| CITY (If outside corporate limits, write RURAL or give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Ft Geo G. Meade</u> | | <u>1 year</u> | | TOWN <u>Charleston</u> | | <u>85X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ft Geo G Meade, Md. USAH</u> | | | | STREET ADDRESS (If rural give location) <u>2831 Piedmont Road</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>William Harlow Groah</u> | | | | <u>Aug 23 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>Apr 27 1911</u> | <u>44</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Soldier</u> | | <u>US ARMY</u> | | <u>West Virginia</u> | | <u>W. Va.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Harlow Groah</u> | | | | <u>Ida Mae Lee</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>Yes</u> <u>15 yrs til present</u> | | <u>unknown</u> | | <u>Mrs. Bessie Groah</u>
<u>1729 C, Forrest Ave, Ft Meade, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>420.1</u> IMMEDIATE CAUSE (A) <u>Acute myocardial infarction, posterior wall</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO <u>left ventricle, Thrombosis circumplex</u> | | | | | | <u>unknown</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>coronary artery</u> | | | | | | | |
| DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>DOA</u> , 19 <u> </u> , to <u>23 August 19 55</u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>MELVIN ROBERT L. SABEL</u> | | | | DATE SIGNED <u>23 Aug 55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | ADDRESS (Street, city, town, state) <u>USAH, Ft GG Meade, Maryland</u> | | | |
| 24. REC'D BY REGISTRAR | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | | | |
| <u>WM. L. SAILOR, 1/Lt MSC</u> | | <u>8-24-55 Sunset Memorial Cemetery</u> | | <u>Charlestown, W. Va.</u> | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | | | | |
| <u>WM. COOK, INC., BALTO., MD.</u> | | | | | | | |

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7370

CERTIFICATE OF DEATH

07348

Film G 186, 9-22-55 Items 13&14 bh

Reg. Dist. No.

| | | | | | | | |
|--|------------------|--|--------------------|---|-----------------|----------------------------------|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>aa</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>AT</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Fair Haven</u> | | <u>20 yrs</u> | | TOWN <u>Fair Haven</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 10 | | | | / | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Daniel</u> (Middle) <u>Gross</u> (Last) | | | | (Month) <u>Aug</u> (Day) <u>27</u> (Year) <u>1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>M</u> | <u>C</u> | | <u>15 May 1882</u> | <u>73</u> yrs. | <u>5</u> Months | <u>5</u> Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Farmer</u> | | <u>Agrie</u> | | <u>Anne Arundel Count.</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Samuel Thomas Gross</u> | | | | <u>Martha Estep</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>217-09-1685A</u> | | <u>Corrie A Smith, Fair Haven, MD</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Congestive Cardiac failure</u> | | | | | | <u>3 Months</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u> | | | | | | <u>Several years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia - 5 mos ago -</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>March</u> , 19....., to <u>April</u> , 19....., that I last saw the deceased alive on <u>April</u> , 19....., and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J. D. Hendricks</u> | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>8/27/55</u> | |
| M.D. <u>Shady Side Maryland</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>Buried</u> | | <u>Aug 29/55</u> | | <u>Union Chapel</u> | | <u>McKendree</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>8/29/55</u> | | <u>Edward Williams</u> | | <u>Bernard Harduty</u> | | | |

CERTIFICATE OF DEATH

1955

07348

MD 2000

FAIR HUGH
MD 2000

MD 2000

FAIR HUGH

DATE OF DEATH

Corrine A. Smith, nee, MD

BUREAU V. S.

SEP 1 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07349

7333

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis</u> | | 75 Yrs. | | TOWN <u>Annapolis</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 07 30 Lafayette Ave. | | | | 30 Lafayette Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) CARRIE (Middle) ELIZABETH (Last) HARRIS | | | | (Month) August 19, (Day) 19 (Year) 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | Colored | Widowed | June 27, 1877 | 78 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | None | | A. A. Co. Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Steven Johnson | | | | Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| No | | None | | Edna Harris - Lafayette Ave. - Annapolis | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 443X IMMEDIATE CAUSE (A) <u>Arteriosclerotic Hypertension</u> | | | | | | 4 months | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular disease grade III</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>May 4, 1953</u> to <u>8/19, 1953</u> , that I last saw the deceased alive on <u>8/19, 1953</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>R. B. Richardson</u> | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>8/22/53</u> | |
| M.D. <u>110 - Clay Street Annapolis, Md</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or County) (State) | |
| Burial | | 8/22/53 | | Asbury Cemetery | | Annapolis, Maryland | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>Aug. 22, 1955</u> | | | | Ethel L. Hicks - 45 Northwest St. Annapolis | | | |

05380

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

333

and Date of

1. USUAL RESIDENT'S NUMBER OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CONSTABLE

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF STATE CLERK

21. SIGNATURE OF NATIONAL CLERK

22. SIGNATURE OF INTERNATIONAL CLERK

23. SIGNATURE OF UNITED STATES CLERK

24. SIGNATURE OF FOREIGN CLERK

25. SIGNATURE OF OTHER CLERK

26. SIGNATURE OF DECEASED'S NEAREST RELATIVE

27. SIGNATURE OF DECEASED'S NEXT OF KIN

28. SIGNATURE OF DECEASED'S EXECUTOR

29. SIGNATURE OF DECEASED'S ADMINISTRATOR

30. SIGNATURE OF DECEASED'S LEGAL REPRESENTATIVE

31. SIGNATURE OF DECEASED'S ATTORNEY

32. SIGNATURE OF DECEASED'S COUNSELOR

33. SIGNATURE OF DECEASED'S ADVISOR

34. SIGNATURE OF DECEASED'S ASSISTANT

35. SIGNATURE OF DECEASED'S CLERK

36. SIGNATURE OF DECEASED'S CHIEF CLERK

37. SIGNATURE OF DECEASED'S DEPUTY CHIEF CLERK

38. SIGNATURE OF DECEASED'S ASSISTANT CHIEF CLERK

39. SIGNATURE OF DECEASED'S CLERK IN CHARGE

40. SIGNATURE OF DECEASED'S CLERK IN CHARGE

41. SIGNATURE OF DECEASED'S CLERK IN CHARGE

42. SIGNATURE OF DECEASED'S CLERK IN CHARGE

43. SIGNATURE OF DECEASED'S CLERK IN CHARGE

44. SIGNATURE OF DECEASED'S CLERK IN CHARGE

45. SIGNATURE OF DECEASED'S CLERK IN CHARGE

46. SIGNATURE OF DECEASED'S CLERK IN CHARGE

47. SIGNATURE OF DECEASED'S CLERK IN CHARGE

48. SIGNATURE OF DECEASED'S CLERK IN CHARGE

49. SIGNATURE OF DECEASED'S CLERK IN CHARGE

50. SIGNATURE OF DECEASED'S CLERK IN CHARGE

51. SIGNATURE OF DECEASED'S CLERK IN CHARGE

52. SIGNATURE OF DECEASED'S CLERK IN CHARGE

53. SIGNATURE OF DECEASED'S CLERK IN CHARGE

54. SIGNATURE OF DECEASED'S CLERK IN CHARGE

55. SIGNATURE OF DECEASED'S CLERK IN CHARGE

56. SIGNATURE OF DECEASED'S CLERK IN CHARGE

57. SIGNATURE OF DECEASED'S CLERK IN CHARGE

58. SIGNATURE OF DECEASED'S CLERK IN CHARGE

59. SIGNATURE OF DECEASED'S CLERK IN CHARGE

60. SIGNATURE OF DECEASED'S CLERK IN CHARGE

BUREAU V. S.

AUG 23 1955

RECEIVED

RECEIVED
 AUG 23 1955
 BUREAU V. S.

1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07350

7334 CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Anne Arundel</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Anne Arundel</i> |
| CITY (If outside corporate limits, write RURAL or end give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| 10 TOWN <i>Annapolis</i> | | OR TOWN <i>Annapolis</i> | 10 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General</i> | | STREET ADDRESS (If rural give location) <i>Bywater Road</i> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| <i>Frederick C. Harris</i> | | <i>Aug. 16 1955</i> | |
| 5 SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 16, 1885</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Superintendent</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <i>70</i> yrs. |
| 13. FATHER'S NAME <i>Frederick C. Harris</i> | | 14. MOTHER'S MAIDEN NAME <i>Marie Wright</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 17. INFORMANT & ADDRESS <i>Mrs. F.C. Harris #2</i> | |
| 16. SOCIAL SECURITY NO. <i>—</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 420.1 IMMEDIATE CAUSE (A) <i>Myo-cardial Infarction</i> | | | <i>5m.</i> |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardio-Vascular Disease</i> | | | <i>2 yrs.</i> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <i>8-16-55</i> | | 21f. HOW DID INJURY OCCUR? | |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 22. I hereby certify that I attended the deceased from <i>Jan. 1953</i>, to <i>Aug. 16, 1955</i>, that I last saw the deceased alive on <i>8-16-55</i>, and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE <i>James R. Mant</i> | | DATE SIGNED <i>8/18/55</i> | |
| M.D. | | ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | LOCATION (City, town, or county) (State) <i>Prince George Co. Md.</i> | |
| DATE THEREOF <i>8-18-55</i> | | NAME OF CEMETERY OR CREMATORY <i>H. Lincoln</i> | |
| 24. REC'D BY REGISTRAR <i>John M. Taylor & Sons</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i> | |
| 24. REC'D BY REGISTRAR SIGNATURE <i>John M. Taylor & Sons</i> | | ADDRESS | |
| DATE <i>Aug. 18, 1955</i> | | | |

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07351

7371

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|--|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNE ARUNDEL</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>ANNE ARUNDEL</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>PASADENA</u> | | <u>2 YRS</u> | | TOWN <u>PASADENA</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3 Box 17</u> | | | | STREET ADDRESS (If rural give location) <u>ROUTE 3 BOX 17</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>MARGARET</u> (First) <u>HATTER</u> (Middle) (Last) | | | | <u>8</u> <u>25</u> <u>1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>F</u> | <u>W</u> | <u>Widowed</u> | <u>APRIL 14 1872</u> | <u>83</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>HOUSEWORK</u> | | <u>AT HOME</u> | | <u>BALTIMORE</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>HENRY TWIST</u> | | | | <u>MARY LOGUE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>NO</u> | | <u>NONE</u> | | <u>LANE LAWRENCE HATTER 1243 MAIDEN CHOICE</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| <u>420.0</u> IMMEDIATE CAUSE (A) <u>Constrictive heart failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>19</u> <u>730</u> <u>AM</u> <u>to</u> <u>19</u> <u>8/25/1955</u> <u>that I last saw the deceased</u> <u>alive on</u> <u>19</u> <u>and that death occurred at</u> <u>102 BALTO ANNAR</u> <u>ADDRESS</u> (Street, city, town, state) <u>DATE SIGNED</u> <u>8/25/1955</u> | | | | | | | |
| SIGNATURE <u>Joseph Taw</u> M.D. <u>McElen Butnic, Ind.</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>AUG 27 55</u> | | <u>NEW CATHEDRAL CEM</u> | | <u>OLD FREDERICK RD MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Aug. 29, 1955</u> | | <u>Louis J. Sciala</u> | | <u>Diffel Bros</u> | | <u>1800 E LOMBARD ST</u> | |

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07352

7372

CERTIFICATE OF DEATH

Film G 186, 9-22-55 Item 12 & 8 bh

Reg. Dist. No. 26

| | | | | | | | |
|--|-------------------------------|--|-------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>MD</u> | | COUNTY <u>AA</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Shodyside</u> | | <u>6 yrs</u> | | TOWN <u>Shodyside MD</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) <u>Gustave</u> (Middle) <u>CARL</u> (Last) <u>Heinrich</u> | | | | August 30 1955 | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>Aug 16 1877</u> | 9. AGE last birthday <u>78</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>System Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>System</u> | | 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | <u>Opheie ERNESTINE GRAPER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Ann H. Howard Shodyside MD</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 4341 IMMEDIATE CAUSE (A) <u>Probable Coronary Occlusion</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Cardiac Failure</u> | | | | 6 months | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) " " " | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb.</u> <u>1955</u> , to <u>Aug.</u> <u>30</u> , <u>1955</u> , that I last saw the deceased alive on <u>Aug. 23</u> , <u>1955</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>H. H. Hendrichs</u> | | | | ADDRESS (Street, city, town, state) <u>M.D. Shady Side, Md.</u> | | | |
| DATE <u>Aug 31 1955</u> | | | | DATE SIGNED <u>31 Aug. 1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>9/1/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | | LOCATION (City, town, or county) <u>Shodyside Md.</u> | |
| 24. REC'D BY REGISTRAR <u>Ida B. Dent</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Galt</u> | | ADDRESS | |
| DATE <u>August 31</u> | | | | | | | |

102305

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 10

CERTIFICATE OF DEATH

55

1. NAME OF DECEASED

MR. J. M. D.

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. SEX

6. AGE

7. OCCUPATION

8. PLACE OF BIRTH

9. DATE OF DEATH

BUREAU V. A.

SEP 6 1910

REC'D

RECEIVED SEP 6 1910

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7373

CERTIFICATE OF DEATH

07353

Reg. Dist. No. 28

| | | | | | | | |
|---|---|---|---------------------------------------|---|--------------------------------|---|--|
| 1. PLACE OF DEATH
COUNTY <u>Anne Arundel</u> MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)
X TOWN <u>Middletonville</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>00</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Md</u> COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN <u>Annapolis</u> 10
STREET ADDRESS (If rural give location)
<u>147 King George St</u> 1 | | | |
| 3. NAME OF DECEASED
(Type or Print) (First) (Middle) (Last)
<u>Bertha V. Hyde</u> | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>AUG 31 1955</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>W</u> | 8. DATE OF BIRTH
<u>10/27/1900</u> | 9. AGE last birthday
<u>54</u> yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Annapolis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>JOHN H. JACOBS</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY E. DRURY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
<u>—</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT & ADDRESS
<u>MRS CAUDELL #2</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
163X IMMEDIATE CAUSE (A) <u>Metastatic cancer of brain</u> | | | | | | <u>6 mths</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of lung</u> | | | | | | <u>1 yr</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
M. at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 1955</u> , to <u>Aug 31 1955</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>John H. Hyde</u> | | | | ADDRESS (Street, city, town, state)
<u>90 Calver St Annapolis, Md.</u> | | DATE SIGNED
<u>8/31/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | DATE THEREOF
<u>9/6/55</u> | NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | | LOCATION (City, town, or county) (State)
<u>Arlington Va.</u> | | | |
| 24. REC'D BY REGISTRAR
<u>22-55</u> | REGISTRAR'S SIGNATURE
<u>K M Joyce</u> | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Lytle & Sons</u> | | ADDRESS
<u>Annapolis, Md.</u> | | | |

BUREAU V. S.

SEP 2 1955

RECEIVED

9225

09342

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *22*

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Anne Arundel | MARYLAND | STATE Maryland | COUNTY |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN Jessup | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN Baltimore | 3701.4 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Md. House of Correction | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED:
(Type or Print) MELVIN KENNETH JOHNSON | 4. DATE OF DEATH
Aug. 15 1955 | | |
| 5. SEX: Male | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: July 11, 1925 |
| 9. AGE last birthday: 30 yrs. | IF UNDER 1 YEAR: 1 Months | IF UNDER 24 HRS. 4 Days | 19 Hours 55 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: Louis F. Johnson | | 14. MOTHER'S MAIDEN NAME: Rosa (Unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: | |

| | | |
|--|--------|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| Immediate cause (a) Stab wound of left side of mouth | DUE TO | |
| Antecedent cause(s) (b) Asphyxiation due to aspiration of blood | DUE TO | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | |

| | | |
|--|---|--|
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Institution | 21c. (City or town) Jessup (County) Anne Arundel (State) Maryland |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8/15/55 11:30 A.M. | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? Stabbed by another inmate at House |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE *William H. [Signature]* CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **8/16/55**
 M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☒

| | | | |
|---|---|---|--|
| 23. BURIAL, CREMATION, REMOVAL (Specify): Cremated | DATE THEREOF: 10/7/55 | NAME OF CEMETERY OR CREMATORY: U. S. Md. Med. Sch. Bldg. 1, Maryland | LOCATION (City, town, or county) (State) |
| DATE REC'D BY LOCAL REG. Oct. 10, 1955 | REGISTRAR'S SIGNATURE: <i>Clara [Signature]</i> | 24. FUNERAL DIRECTOR: The Anatomy Board of Maryland | ADDRESS: per: M. Christie |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 11 1953

BUREAU A. S.

Investigation of ...

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07354

Item 21b Film G186 9-8-55

7374

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|--|--|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>A. A.</i> | | MARYLAND | | STATE <i>Md.</i> | | COUNTY <i>A. A.</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Annapolisneck</i> | | | | TOWN <i>Annapolisneck</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <i>Sheilah Maxine Johnson</i> | | | | <i>Aug 15 1955</i> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <i>Female</i> | | <i>Colored</i> | | <i>single</i> | | <i>Apr 29 1905</i> | |
| 9. AGE last birthday | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>3</i> | | <i>none</i> | | <i>Washington D.C.</i> | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>Richard R. Johnson</i> | | | | <i>Lovel Parker</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| | | | | | | <i>Marie Johnson</i> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 921.0 IMMEDIATE CAUSE (A) | | | | <i>Asphyxia due to inspirator</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <i>Embolus.</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | <i> sudden</i> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | <i>Home</i> | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Aug 15 1955</i> to <i>Aug 15 1955</i> , that I last saw the deceased alive on <i>Aug 15 1955</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <i>Sheilah Johnson</i> | | | | <i>Annapolisneck</i> | | <i>8/16/55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <i>Burial</i> | | <i>Aug 18/55</i> | | <i>Trinity</i> | | <i>Annapolisneck Md</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <i>Aug 22, 1955</i> | | <i>J. B. Johnson</i> | | <i>J. B. Johnson</i> | | <i>Annapolis</i> | |

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1957

DATE OF DEATH

PLACE HERE THE WORDS "DECEASED"

MARYLAND

STATE OF

CITY OF

ZIP CODE

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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BUREAU V. 1

AUG 23 1957

RECEIVED

NOTIFICATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07355

7335

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------|--|------------------|---|----------------------------------|---|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>A. A. Co.</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>A. A. Co.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR TOWN | |
| 10 TOWN <u>ANNA POLIS</u> | | | | TOWN <u>ANNA POLIS</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| 00 <u>4 CARVER ST</u> | | | | <u>4 CARVER ST</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>William</u> (Middle) (Last) <u>JOHNSON</u> | | | | Month <u>8</u> Day <u>1st</u> Year <u>1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>M</u> | <u>Colored</u> | <u>Married</u> | <u>1-8-1891</u> | <u>64</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Laborer</u> | | <u>---</u> | | <u>MARYLAND</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Johnson</u> | | | | <u>MARY ELIZA JOHNSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>Ann. Md</u>
<u>Miss Jessie Johnson, 4 Carver St</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 7824 IMMEDIATE CAUSE (A) <u>Cardiac failure</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work | | 21i. HOW DID INJURY OCCUR? | | | |
| | | M. <input type="checkbox"/> M. <input type="checkbox"/> | | | | | |
| 22. I hereby certify that I attended the deceased from <u>3-10-55</u> to <u>8-1-55</u> , that I last saw the deceased alive on <u>7-26-55</u> , and that death occurred at <u>1:35</u> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W. J. French</u> | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>8-1-55</u> | |
| M.D. <u>W. J. French</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>8-3-55</u> | | <u>St Mary</u> | | <u>Annapolis, Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>Aug 30, 1955</u> | | <u>Wm. J. French</u> | | <u>William Reese</u> | | <u>108 H. Wash St</u>
<u>Annapolis, Md</u> | |

07355

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1955

Reg. Dist. No.

AT USUAL RESIDENCE (NUMBER OR LOCATION)

PLACE OF DEATH

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

DATE OF REGISTRATION

PLACE OF REGISTRATION

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PLACE OF REGISTRATION

DATE OF REGISTRATION

PLACE OF REGISTRATION

PHOTOGRAPH

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF [COUNTY], MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF [CITY], MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, STATE OF MARYLAND, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, UNITED STATES OF AMERICA.

BUREAU V. S.

AUG 30 1955

RECEIVED

8-3-55

13

William [Name] [Address] [City] [State] [Zip]

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

Item 18 FilmG186 9-12-55 ams

7375

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH-
COUNTY <u>aa</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE <u>D.C.</u> COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 416</u> | | STREET ADDRESS <u>1421 P St. N.E.</u> ✓ | |
| 3. NAME OF DECEASED
(Type or Print) <u>Joan</u> (First) (Middle) (Last) | | 4. DATE OF DEATH <u>8-28-1955</u> (Month) (Day) (Year) | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Single</u> | 8. DATE OF BIRTH <u>July 27, 1935</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cleaner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Warehouse</u> | 9. AGE last birthday <u>20</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John J. Joy.</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Powers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY No. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Mary D. Joy.</u> (2) | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

816X Immediate cause (a) Collision & Fire

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Auto-Auto collision

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | | | |
|---|--|---|--|---|-------------------------------|---------|
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Street</u> | | (CITY OR TOWN) <u>Bristol</u> | (COUNTY) <u>A.P. Maryland</u> | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-28-55 3:00AM</u> | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | HOW DID INJURY OCCUR? <u>Collision & fire</u> | | |

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | | |
|---|--|--|--|--|-------------------|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>8-30-55</u> | NAME OF CEMETERY OR CREMATORY <u>Ht Lincoln Cent</u> | LOCATION (City, town, or county) <u>Bristol</u> | (State) <u>MD</u> |
| DATE REC'D BY LOCAL REG. <u>Aug. 28, 1955</u> | | REGISTRAR'S SIGNATURE <u>Chas. W. Williams</u> | | 24. FUNERAL DIRECTOR <u>Francis Gasch + Sons, Hyattsville, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

SEP 1 1955

RECEIVED
BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07357

7376

CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN PASADENA
HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN PASADENA, MD. (RURAL)
STREET ADDRESS Boulevard Park | |
| 3. NAME OF DECEASED (Type or Print)
CHARLES W. KAISER | | 4. DATE OF DEATH
Month 8 Day 27 Year 1955 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH
Sept 22, 1893 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY
GENERAL | 9. AGE last birthday
61 yrs. |
| 11. BIRTHPLACE (State or foreign country)
HARFORD COUNTY MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHARLES KAISER | | 14. MOTHER'S MAIDEN NAME
MARY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
NO | | 16. SOCIAL SECURITY NO.
--- | |
| 17. INFORMANT & ADDRESS
WILLIAM KAISER PASADENA, MD. | | 18. MEDICAL CERTIFICATION
Carcinomatosis general
Carcinoma of rectum | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
154X IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO (B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. | | | |
| SIGNATURE
Joseph Taler | | ADDRESS (Street, city, town, state)
102 Balto - Annapolis Rd. Glen Burnie, Md. | |
| DATE SIGNED
8/27/1955 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | DATE THEREOF
AUG 30 1955 | NAME OF CEMETERY OR CREMATORY
GIEN HAVEN | LOCATION (City, town, or county) (State)
GIEN BURNIE, MD. |
| 24. REC'D BY REGISTRAR
Aug 31, 1955 | REGISTRAR'S SIGNATURE
L. J. DeAlba | 25. FUNERAL DIRECTOR'S SIGNATURE
W. D. Singleton | ADDRESS
Glen Burnie, Md. |

BUREAU V. S.

SEP 2 1955

RECEIVED

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|---|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Anne Arundel</u> MARYLAND | | STATE <u>Maryland</u> COUNTY | |
| CITY (If outside corporate limits, write RURAL or and give nearest town)
TOWN <u>Annapolis</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Homewood Convalescent Home</u> | | STREET ADDRESS (If rural give location)
<u>705 N. Duncan Street</u> | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
<u>ELIZABETH</u> <u>KNUDSEN</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>August 5, 1955</u> | |
| 5. SEX: <u>female</u> | 6. COLOR OR RACE: <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | 8. DATE OF BIRTH: <u>Feb. 20, 1877</u> |
| 9. AGE last birthday <u>78</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Newark, New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME: <u>Frederick A. Werner</u> | | 14. MOTHER'S MAIDEN NAME: <u>Dorothea W. Kraemer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS: <u>1509 E. Mrs. Wilhelmina Pyles, Lafayette Ave</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
<u>592x</u>
IMMEDIATE CAUSE
ANTECEDENT CAUSE (S):
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
<u>Arteriosclerosis C.V. Cholesterol</u>
<u>Chr. Nephritis</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>yes.</u>
<u>yes.</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>8/4</u> , 19 <u>55</u> , to <u>8/5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>8/4</u> , 19 <u>55</u> , and that death occurred at <u>7:45 A</u> M. from the causes and on the date stated above.
SIGNATURE <u>Maurice Klawans</u> M. D. ADDRESS <u>Annapolis Md</u> DATE SIGNED <u>8/5/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u> | | DATE THEREOF <u>8/6/55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>August 5 1955</u> | | REGISTRAR'S SIGNATURE <u>RA. NO.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. Gode Inc.</u> | | ADDRESS <u>1217 St. Paul Street</u> | |

7377

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|-------------------|--|-------------------|--|-----------------|--|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| X TOWN <u>LAUREL</u> | | 3 yrs. | | TOWN <u>LAUREL</u> Washington, D. C. | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>District Training School</u> | | | | STREET ADDRESS <u>804 Eye St., N. W.</u> (If rural give location) <u>47X-3</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH: (Month) (Day) (Year) | | | |
| DECEASED: (Type or Print) <u>Estelle</u> <u>-</u> <u>LAU</u> | | | | DATE OF DEATH: <u>August 20</u> <u>1955</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| Female | Chinese | Single | August 10, 1950 | 5 yrs. | Months | Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| None | | None | | Washington, D. C. | | U.S.A. | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| GUY SEN LAU | | | | Shirley Lee | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | | | |
| No | | None | | District Training School's files | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cardiac Failure</u> | | | | | | 3 days | |
| ANTECEDENT CAUSE (S) <u>Intestinal Toxemia</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Asthenia</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH (C) <u>(1) Microcephalic Idiot</u> <u>(2) Congenital cerebral spastic infantile paralysis</u> | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug. 18</u> , 1955, to <u>Aug. 20</u> , 1955, that I last saw the deceased alive on <u>August 20</u> , 1955, and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Maureen Wang mola</u> | | ADDRESS <u>M. D. District Training School</u> | | DATE SIGNED <u>August 20 1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Aug 22 55</u> | | <u>West View School</u> | | <u>Laurel RFD Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Aug 26 - 55</u> | | <u>Clara H. H. H.</u> | | <u>W. H. H. H.</u> | | <u>Laurel Md</u> | |

BUREAU V. S.

SEP 13 1953

RECEIVED

CERTIFICATE OF DEATH

Item 18 Film G186 9-13-55 ams

FOR MEDICAL EXAMINERS

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH-
COUNTY <u>A.A.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>
TOWN <u>Bristol</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 416</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE <u>D.C.</u> COUNTY <u>Washington</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>
TOWN <u>Washington</u>
STREET ADDRESS <u>219 - 115th St N.E.</u> | |
| 3. NAME OF DECEASED
(Type or Print) <u>Phyllis Ann Leech</u> | | 4. DATE OF DEATH <u>8-28-1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>May 14-1940</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u> | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u> |
| 13. FATHER'S NAME <u>Louis F. Leech</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 17. INFORMANT AND ADDRESS <u>Louis F. Leech - (2)</u> | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

816X Immediate cause (a) Collision & Fire

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Auto-Auto collision

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) Street
INJURY Bristol A.A. MarylandTIME (Month) (Day) (Year) (Hour) OF INJURY 8-28-55 3:00 AMINJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Collision & Fire

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug 28, 1955Edw. W. WilliamsW.W. Chambers Co. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 1 1955

RECEIVED

7379

CERTIFICATE OF DEATH

Items 13,14 Film 185 8-25-55 et

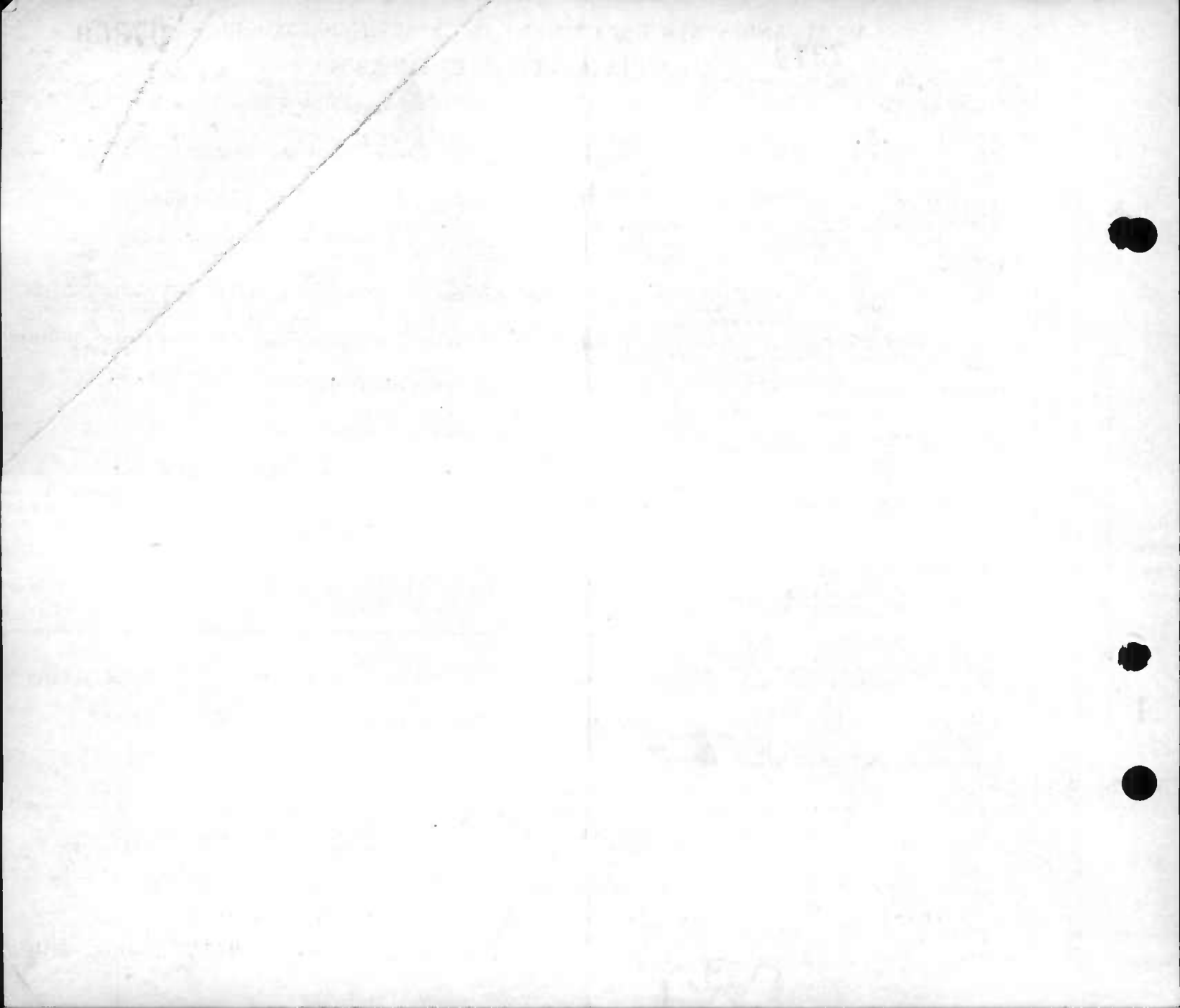
Reg. Dist. No.

| | | | | | | | |
|---|--|--------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>A.A.</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>A.A.</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| <u>50</u> TOWN <u>Brooklyn</u> | | | | TOWN <u>Brooklyn</u> | | <u>50</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4103 Ritchie Hwy.</u> | | | | STREET ADDRESS (If rural give location) <u>4103 Ritchie Hwy.</u> | | | |
| 3. NAME OF DECEASED: | | (First) <u>Dorra</u> | | (Middle) <u>E.</u> | | (Last) <u>Lipp</u> | |
| (Type or Print) | | | | | | | |
| 5. SEX: <u>F</u> | | 6. COLOR OR RACE: <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | | 8. DATE OF BIRTH: <u>Oct. 2, 1884</u> | |
| | | | | | | 9. AGE last birthday: <u>71</u> yrs. | |
| | | | | | | 10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u> | |
| | | | | | | 11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u> | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>Frank Sieble</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Dora Coasy</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: <u>John J. Lipp 4103 Ritchie Hwy.</u> | |

| | | | | | |
|--|--|---|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | Interval Between Onset And Death | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | |
| 420.1 Immediate cause (a) <u>Coronary occlusion</u> | | | | | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Cardio vascular disease</u> | | | | | |
| (c) <u>none</u> | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>July 19, 1955</u> , to <u>July 17, 1955</u> , that I last saw the deceased alive on <u>Aug 3, 1955</u> , and that death occurred at <u>4:00 pm</u> , from the causes and on the date stated above. | | | | | |
| SIGNATURE <u>James Greber</u> | | (Degree or title) <u>M.D.</u> | | ADDRESS <u>4016 Ritchie Highway</u> DATE SIGNED <u>8/16/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF <u>Aug 18, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> LOCATION (City, town, or county) <u>A.A. Co.</u> (State) <u>Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>8/18/55</u> | | REGISTRAR'S SIGNATURE <u>Adelheid</u> | | 24. FUNERAL DIRECTOR <u>George J. Gonce</u> ADDRESS <u>4001 Ritchie Hwy</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7380

CERTIFICATE OF DEATH

Items 2,9, Film 186 9-16-55 et

Reg. Dist. No. 22

| | | | | | | | |
|---|-------------------|---|-------------------|---|-----------------|---|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE Maryland | | COUNTY Anne Arundel | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
X TOWN Laurel, Md. | | LENGTH OF STAY (in this place)
12yrs.5 mos. | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Laurel, Maryland | | Washington, D.C. | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
District Training School | | | | STREET ADDRESS
805 N St. N.W. District Training School | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH: | | | |
| (First) Bertha | | (Middle) Theresa | | (Last) Lyles | | (Month) August | |
| (Type or Print) | | | | | | (Day) 29 | |
| | | | | | | (Year) 19 55 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | | |
| Female | Negro | Single | 3/13/39 | 16 12 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None | | | | 10b. KIND OF BUSINESS OR INDUSTRY: None | | 11. BIRTHPLACE (State or foreign country): Washington, D. C. | |
| 12. FATHER'S NAME: 2 | | | | 14. MOTHER'S MAIDEN NAME: Thelma Lyles | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | | | | 16. SOCIAL SECURITY No.: None | | 17. INFORMANT & ADDRESS: District Training School records | |

| | | | | | | | |
|---|--|--|--|---|--|-------------|--|
| 11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | | Interval Between Onset And Death | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 2. CITIZEN OF WHAT COUNTRY? | | | |
| 3250
Immediate cause
Otitis media Septicemia
Congenital cerebro spasm and
isliocy due to birth trauma
Antecedent causes(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | | | | USA
16 years | | | |
| 19a. DATE OF OPERATION: 2 | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | | | 20. AUTOPSY ? | | | |
| PLACE (Home, farm, factory, street, office bldg., etc.) | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | HOW DID INJURY OCCUR ? | | | |
| INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I hereby certify that I attended the deceased from 15 Aug., 1955 , to 29 Aug., 1955 , that I last saw the deceased alive on 29 Aug., 1955 , and that death occurred at 9:55 AM from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS | | DATE SIGNED | |
| Francis Mastrolia | | | | Medical officer District Training School Laurel | | MD | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | | | 24. FUNERAL DIRECTOR | | | |
| DATE THEREOF | | | | ADDRESS | | | |
| Burial | | | | W. F. School Cemetery Laurel, Md | | | |
| DATE REC'D BY LOCAL REGISTRAR | | | | ADDRESS | | | |
| Aug 31-55 | | | | Dist Training School, Aug 31-55 | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 13 1955

RECEIVED

and of 2-2-55 [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07361
Reg. Dist.

No. 28

| | | | | | | | |
|---|--|--------------------------------|--|--|---|---|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>D.C.</u> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| X TOWN <u>Fort Meade, Maryland</u> | | | | TOWN <u>Washington</u> 47X -3 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fort Meade Hospital</u> | | | | STREET ADDRESS (If rural, give location) <u>300 G. St., N.W.</u> | | | |
| 3. NAME OF DECEASED:
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) <u>VIRGINIA (DOLLY) FRANCES MARSH</u> | | | | (Month) (Day) (Year) <u>August 15 19 55</u> | | | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| <u>Female</u> | | <u>White</u> | | <u>Married</u> | | <u>Dec. 15, 1910</u> 44 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u> | | 11. BIRTHPLACE (State or foreign country): <u>Virginia</u> | |
| 13. FATHER'S NAME: <u>Newell Walton</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Melinda Roston</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>--</u> (If Yes, give war or dates of service) <u>--</u> | | | | 16. SOCIAL SECURITY No.: <u>---</u> | | 17. INFORMANT & ADDRESS: <u>Va. Preddy Funeral Home, Charlottesville,</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| <u>816X</u>
Immediate cause (a) <u>Crushing injury of chest</u>
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Street</u> | | 21c. (City or town) (County) (State)
<u>Fort Meade Anne Arundel Maryland</u> | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8/15/55 2:45 P.M.</u> | | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR?
<u>Auto-auto collision</u> | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>William Updegraff</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>8/16/55</u>
M. D. | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u> | | | DATE THEREOF <u>8/17/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Charlottesville</u> | | LOCATION (City, town, or county) (State)
<u>Charlottesville, Va.</u> |
| DATE REC'D BY LOCAL REG. <u>8-17-55</u> | | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 24. FUNERAL DIRECTOR ADDRESS
<u>New Look, Inc., 1217 St. Paul Street</u> | | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7337

CERTIFICATE OF DEATH

07362

Reg. Dist. No. 21

| | | | | | | | |
|---|------------------|--|----------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Anne Arundel</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Anne Arundel</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <i>Annapolis</i> | | 3 days | | TOWN <i>Westport - Balto. 30</i> | | x | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 63 <i>Anne Arundel Gen'l. Hosp.</i> | | | | 2212 <i>Annapolis Rd.</i> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <i>Thomas Patrick McKewen</i> | | | | <i>Aug. 17, 1955</i> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <i>Male</i> | <i>White</i> | <i>Widowed</i> | <i>Nov. 19, 1898</i> | <i>66</i> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Plant Engineer</i> | | <i>Koppers Co.</i> | | <i>Baltimore, Md.</i> | | <i>U.S.A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <i>John McKewen</i> | | | | <i>Elizabeth Nally</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <i>No</i> | | <i>241-05-3107</i> | | <i>Thomas D. McKewen, Box 495, Shore Acres, Pasadena, Md.</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 443X IMMEDIATE CAUSE (A) | | | | <i>1 Cerebral Thrombosis</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | | <i>2 Nerve Lesion</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | <i>3 Hypertension & Diabetes</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Dec 15, 1954</i> to <i>17 Aug, 1955</i> , that I last saw the deceased alive on <i>Aug 15, 1955</i> and that death occurred at <i>8:15 PM</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Wm. J. French</i> | | | | ADDRESS (Street, city, town, state) <i>Severna Park, Md.</i> | | | |
| DATE <i>Aug 31, 1955</i> | | | | DATE SIGNED <i>17 Aug 55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>Aug. 30, 1955</i> | | <i>Glen Haven</i> | | <i>Glen Burnie Md.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| | | <i>Wm. J. French</i> | | <i>P. J. Ling. Jr.</i> | | <i>Glen Burnie, Md.</i> | |
| DATE <i>Aug 31, 1955</i> | | <i>L. J. De Alba</i> | | | | | |

BUREAU V. S.

SEP 2 1955

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7339
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07363

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

| | | | | | | | |
|---|-------------------|---|-------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Anne Arundel | | MARYLAND | | STATE Maryland | | COUNTY Anne Arundel | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
10 TOWN | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
000 | | Annapolis-City Dock | | STREET ADDRESS | | (If rural, give location)
1 | |
| 3. NAME OF DECEASED:
(Type or Print) | | (First) CHARLES | | (Middle) NEWSOME | | (Last) | |
| 4. DATE OF DEATH | | (Month) Aug. 23 | | (Day) | | (Year) 19 55 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| Male | White | Married | Nov. 17, 1900 | 54 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| House Painter | | | | Shoshier N.C. | | | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| James Newsome | | | | Bessie Louise | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| no | | | | | | Mrs Bessie Carpenter Laurel Md. | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| 929.8 Immediate cause (a) Drowning | | | | | | | |
| DUE TO | | | | | | | |
| Antecedent cause(s) (b) | | | | | | | |
| Diseases or conditions, if any, giving rise to the above cause DUE TO | | | | | | | |
| stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY water | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Found 8/23 3:30 M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | Body found by youngster while crabbing | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> . | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Paul Newsome | | Aug 25/55 | | Lone Hill | | Laurel P. G. Md. | |
| DATE REC'D BY LOCAL REG | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| Aug 25-1955 | | Jm. J. French | | D. W. H. Donaldson | | Laurel, Md. | |

RECEIVED

AUG 31 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07364

7382 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNE ARUNDEL</u> | | STATE <u>MD.</u> COUNTY <u>3V01-4</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | | OR TOWN <u>BALTIMORE</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u> | | LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural give location) <u>1923 DIVISION ST.</u> | | ADDRESS <u>✓</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONV. HOME Route 2 Box 370A</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>VIOLET</u> (First) <u>NIXON</u> (Last) | | | | <u>8</u> <u>2</u> <u>1955</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>MAR. 29, 1898</u> | | 9. AGE last birthday <u>57</u> yrs. | | IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>LAWRENCE CLEMENTS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S ADDRESS <u>MRS. CLEMENTS NIXON 2200 BRADDISH AVE.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC Heart disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis general</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>July 30, 1955</u> to <u>Aug 2, 1955</u> that I last saw the deceased alive on <u>July 30, 1955</u> and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph TALER</u> | | 102 BALTO-ANNA? ADDRESS (Street, city, town, state) <u>BLVD. GLENBURNIE, MD.</u> | | DATE SIGNED <u>8/3/1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>Aug. 6 '55</u> | | NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u> | | LOCATION (City, town, or county) <u>BALTIMORE, MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Louis J. DeAlto</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. ...</u> | | | |
| DATE <u>Aug 5, 1955</u> | | | | ADDRESS <u>1631 Knoll Hill Ave.</u> | | | |

03384

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

DEPT. OF HEALTH

DEATH IN HOUSE - WHEN IN HOUSE

MARYLAND

STATE OF MARYLAND

DECEASED

MEDICAL CERTIFICATE

INSTRUCTIONS

BUREAU V. 8

AUG 5 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7339

CERTIFICATE OF DEATH

07365

Reg. Dist. No.....

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis, Md.</u> | | 27 days | | OR TOWN <u>Glen Isle, Riva, Md.</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel Gen. Hosp. Franklin St.</u> | | | | STREET ADDRESS (If rural give location) <u>/</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Melissa Carrie O'Callaghan</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>August 15, 1955</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 28, 1892</u> | 9. AGE last birthday <u>63</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Williamson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Mr. Edwin A. O'Callaghan Riva, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 153X IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u> | | | | | | 1 month | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Papillary adenocarcinoma- primary site</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>undetermined.</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION <u>July 23, 1955</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Intestinal obstruction</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 11, 1955</u> to <u>Aug. 15, 1955</u> , that I last saw the deceased alive on <u>Aug. 11, 1955</u> , and that death occurred at <u>3:25 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Jane L. Wilkins</u> | | M.D. <u>98 Cathedral St. Annapolis, Md.</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED <u>Aug/ 15, 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>8-17-1955 by J. O'Line</u> | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | | (State) | |
| 24. REC'D BY REGISTRAR <u>Aug. 16, 1955</u> | | REGISTRAR'S SIGNATURE <u>Am. J. Funches</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mattingly</u> | | ADDRESS <u>131-11 Ave Wash. DC</u> | |

BUREAU V. S.

AUG 16 1955

RECEIVED

24.10.1951

8-15-1935
J. L. Williams

8-15-1925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7382
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07366
Reg. Dist.

No. 28

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| TOWN <u>Samuelsville</u> | | <u>25 years</u> | | TOWN <u>Samuelsville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 301</u> | | | | STREET ADDRESS (If rural, give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
<u>Lucia Mary O'Keefe</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Aug. 29 1955</u> | | | |
| 5. SEX:
<u>F</u> | | 6. COLOR OR RACE:
<u>W.</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
<u>married</u> | | 8. DATE OF BIRTH:
<u>Aug. 20-1872</u> | |
| | | | | 9. AGE last birthday: <u>83</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife Own Home</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY:
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country): <u>Ireland, Europe</u> | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>Ireland</u> ✓ | |
| 13. FATHER'S NAME:
<u>James Wallace</u> | | | | 14. MOTHER'S MAIDEN NAME:
<u>Margaret O'Shea</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS:
<u>Mr. Timothy A. O'Keefe (head of household)</u> | | | |
| | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.1</u>
Immediate cause (a) <u>Coronary Occlusion</u> | | | | | | <u>Sudden</u> | |
| DUE TO | | | | | | | |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. PLACE (Home, farm, factory, of street, office bldg., etc., INJURY) | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | |
| SIGNATURE
<u>Paula X Paubert</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>8/29/55</u>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify):
<u>Burial</u> | | DATE THEREOF
<u>9-1-1955</u> | | NAME OF CEMETERY OR CREMATORY
<u>Our Lady of the Field</u> | | LOCATION (City, town, or county) (State)
<u>Mallinville, Maryland</u> | |
| DATE REC'D BY LOCAL REG.
<u>August 31, 1955</u> | | REGISTRAR'S SIGNATURE
<u>L. J. D'Alba</u> | | 24. FUNERAL DIRECTOR
<u>R. L. Singleton - Glen Burnie</u> | | ADDRESS | |
| | | | | | | | |

BUREAU V. 2

SEP 2 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7340

CERTIFICATE OF DEATH

07367

Reg. Dist. No. 21

| | | | | | | | |
|--|-------------------------------|--|-----------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Anne Arundel</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Anne Arundel</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <i>Annapolis</i> | | | | TOWN <i>Annapolis</i> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>USN Experimental Stz.</i> | | | | STREET ADDRESS (If rural give location) <i>USN Experimental Station</i> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <i>OSCAR</i> (Middle) <i>W.</i> (Last) <i>OLSON</i> | | | | (Month) <i>Aug</i> (Day) <i>18</i> (Year) <i>1953</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widower</i> | 8. DATE OF BIRTH <i>10-2-1883</i> | 9. AGE last birthday <i>71</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| | | | | Months | | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boiler Maker</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Sweden</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13. FATHER'S NAME <i>Andrew P. Olson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Not known</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <i>Daniel C. Olson #2</i> | | | |
| (If Yes, give war or dates of service) | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 162X IMMEDIATE CAUSE (A) <i>Carcinoma lung. (bronchogenic)</i> | | | | | | <i>6-8 mos</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma of lung</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>6/29/53</i> , 19 <i>53</i> , to <i>8/18</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>8/12</i> , 19 <i>53</i> , and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>S. Borromy</i> | | M.D. <i>Amos Gurnet</i> | | ADDRESS (Street, city, town, state) <i>Amos Gurnet, 51815</i> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>8/20/53</i> | | NAME OF CEMETERY OR CREMATORY <i>Fairfield Memorial</i> | | LOCATION (City, town, or county) (State) <i>Stamford Conn.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor</i> | | ADDRESS <i>Amos Gurnet, 51815</i> | |
| DATE <i>Aug. 19, 1953</i> | | | | | | | |

RECEIVED

AUG 22 1955

BUREAU V. 3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

013801

NOTATION
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-22-2001 BY 60322 UCBAW/STP

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7384

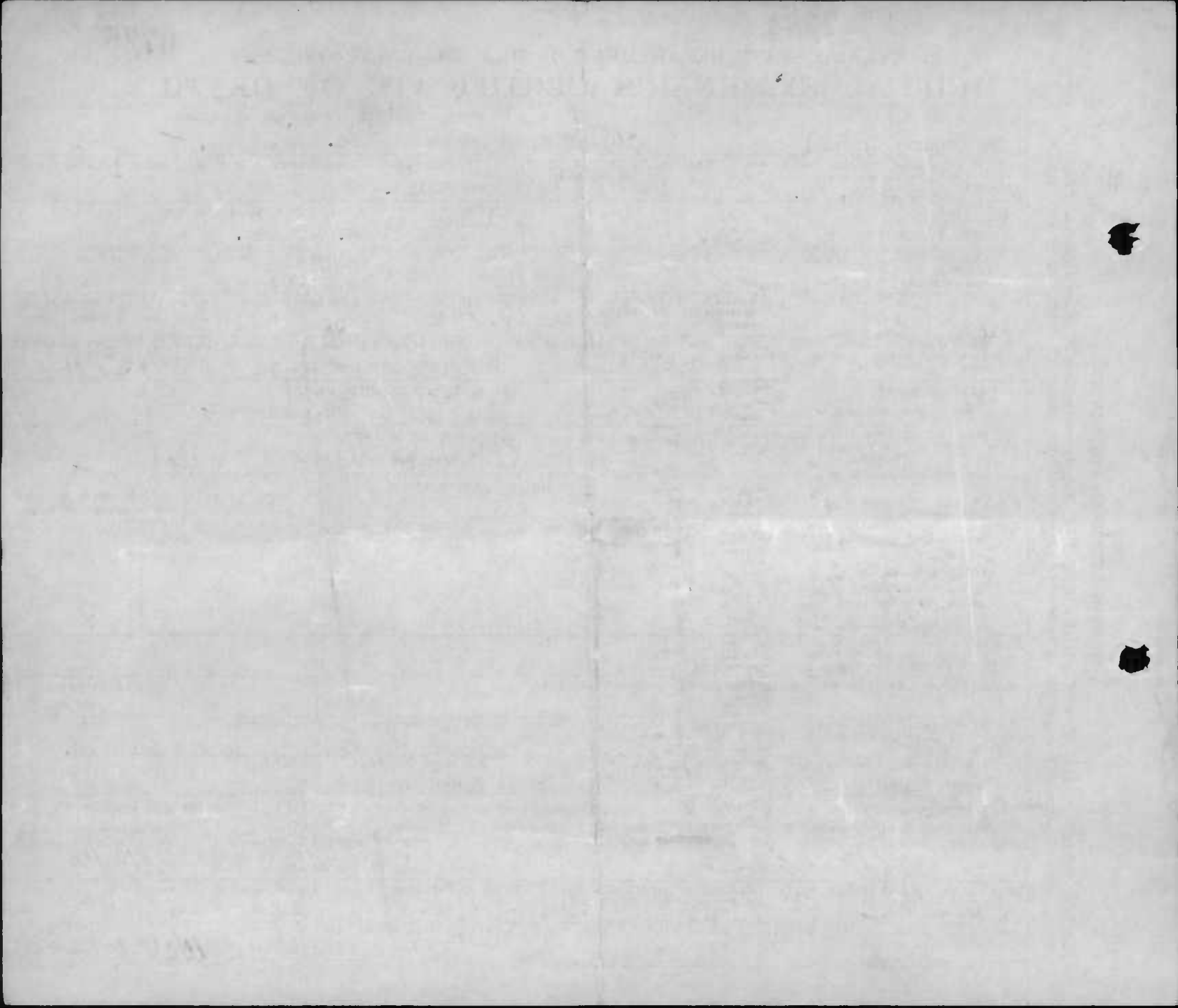
07368
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 24

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Md.</u> COUNTY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) OR | | | |
| X TOWN <u>Pasadena, Md.</u> | | | | TOWN <u>Balto.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u> | | | | STREET ADDRESS (If rural, give location) <u>136 S. Bond St.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) <u>HERMAN</u> | | (Middle) <u>PATTERSON</u> | | (Last) | |
| | | | | 4. DATE OF DEATH <u>August 22</u> | | 19 <u>55</u> | |
| 5. SEX: <u>Male</u> | | 6. COLOR OR RACE: <u>Colored</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>None</u> | | 8. DATE OF BIRTH: <u>6-18-1945</u> | |
| | | | | 9. AGE last birthday: <u>10</u> yrs. | | 10. IF UNDER 1 YEAR: Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u> | | 11. BIRTHPLACE (State or foreign country): <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Thomas Patterson</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Ethel McLean</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>None</u> | | 17. INFORMANT & ADDRESS: <u>Ethel Patterson same</u> | | | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| <p>9299 Immediate cause (a) <u>Drowning</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) <u>None</u></p> <p>Diseases or conditions, if any, giving rise to the above cause (c) <u>None</u></p> <p>stating underlying cause last</p> | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>water</u> | | 21c. (City or town) (County) (State) | | | |
| | | | | <u>Found: Pasadena Anne Arundel Md.</u> | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY found <u>8/22/55</u> M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Found drowned</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>R. F. W. W.</u> | | CHIEF MEDICAL EXAMINER | | DEPUTY MEDICAL EXAMINER | | DATE SIGNED <u>8/23/55</u> | |
| | | M. D. | | ASSISTANT MEDICAL EXAM. | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF <u>8-25-55</u> | | NAME OF CEMETERY OR CREMATORY <u>My Calvary Cem</u> | | LOCATION (City, town or county) (State) <u>Brooklyn Md</u> | |
| DATE REC'D BY LOCAL REG. <u>8/25/55</u> | | REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u> | | 24. FUNERAL DIRECTOR <u>Chas. S. Wilson</u> | | ADDRESS <u>2004 Orleans St</u> | |



7341
CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | |
|---|---|---|--------------------------------------|
| 1. PLACE OF DEATH: <i>Long Trundel</i> | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>ANNAPOLIS</i> | MARYLAND | STATE <i>MD</i> | COUNTY <i>Edgewater Md.</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>ANNAPOLIS</i> | LENGTH OF STAY (in this place) <i>1 Month</i> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Selby or the Bay</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Honewood Convalescent Home</i> | | STREET ADDRESS (If rural, give location) <i>1</i> | |
| 3. NAME OF DECEASED: (First) <i>ALMA</i> (Middle) (Last) <i>PAULSEN</i> | | 4. DATE OF DEATH: (Month) <i>8</i> (Day) <i>22</i> (Year) <i>1955</i> | |
| 5. SEX: <i>Female</i> | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>MARRIED</i> | 8. DATE OF BIRTH: <i>MAR 21 1884</i> |
| 9. AGE last birthday: <i>71</i> yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country): <i>Pa</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME: <i>Samuel E. Jones</i> | | 14. MOTHER'S MAIDEN NAME: <i>Thelma J. Brown Hathi Fink</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: | |
| 17. INFORMANT & ADDRESS: <i>Mrs. Thelma J. Brown 1376 Bryant St NE Washington D.C.</i> | | | |

| | | |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | |
| 420.0 Immediate cause (a) <i>Arteriosclerotic Heart Disease</i> | | <i>unknown</i> |
| Antecedent cause(s) (b) <i>Generalized Arteriosclerosis</i> | | <i>unknown</i> |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | |

| | | |
|---|---|--|
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

| | | | |
|---|--|--|--|
| 22. I hereby certify that I attended the deceased from <i>8/19</i> , 1955, to <i>8/22</i> , 1955, that I last saw the deceased alive on <i>8/21</i> , 1955, and that death occurred at <i>6:20 A.M.</i> , from the causes and on the date stated above. | | | |
| SIGNATURE <i>Edward S. Beebe</i> | | DATE SIGNED <i>8/22/55</i> | |
| (DEGREE OR TITLE) ADDRESS <i>MD 41 Southgate Ave Annapolis</i> | | (State) | |
| 23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i> | DATE THEREOF <i>8-25-55</i> | NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i> | LOCATION (City, town, or county) <i>Annapolis, Md.</i> |
| DATE REC'D BY LOCAL REG. <i>Aug. 22, 1955</i> | DECEASED'S SIGNATURE <i>T.W. Knott</i> | 24. FUNERAL DIRECTOR ADDRESS <i>W.W. Chambers Co. 5801 Cleveland Ave. Riverdale, Md.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 8.

AUG 25 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07370

7342

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis</u> | | | | OR TOWN <u>Riva.</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>/</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>VICTORIA PHILLIPS</u> | | | | <u>August 20, 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Female</u> | <u>White</u> | <u>Divorced</u> | <u>10-8-1871</u> | <u>83</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT & ADDRESS <u>Hospital records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> | | | | | | <u>48 hrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u> | | | | | | <u>yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) | | | | | | | |
| STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from....., 1952, to..... 8/20, 1955, that I last saw the deceased alive on..... 8/20, 1955, and that death occurred at 6:35A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Frank M. Shipley</u> | | | | ADDRESS (Street, city, town, state) <u>Annapolis Md</u> | | DATE SIGNED <u>8/28/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>August 29 55</u> | | NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>8-29-55</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> | | ADDRESS <u>ANNAPOLIS, MD.</u> | |

2000

AUG 30 1955

RECEIVED

7385

CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | | | |
|---|-------------------|---|---------------------|---|----------------------------------|---|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>P.A.Co.</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Pasadena P.O.</u> | | <u>17 months</u> | | X TOWN <u>Pasadena P.O.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>Belhaven ave. Belhaven Beach</u> | | | | <u>Belhaven ave. - Belhaven Beach</u> | | | |
| 3. NAME OF DECEASED: | | (First) (Middle) (Last) | | 4. DATE OF DEATH: | | (Month) (Day) (Year) | |
| <u>Esther</u> | | <u>Mary</u> <u>Platzke</u> | | <u>August 8</u> | | <u>1955</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>Feb. 14-1883</u> | <u>72 yrs.</u> | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Housework (Ret.)</u> | | | | <u>own home</u> | | <u>Deerfield, Georgia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>William James Wallace</u> | | | | <u>Mary Street</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| <u>No</u> | | | | <u>None</u> | | <u>Belhaven Beach</u>
<u>Herman W. Platzke Pasadena, Md.</u> | |

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| 18. MEDICAL CERTIFICATION | | Interval Between Onset And Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| <u>420.1</u> | | |
| Immediate cause | (a) <u>Coronary Thrombosis</u> | <u>45 mins.</u> |
| Antecedent causes (s) | DUE TO | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | (b) <u>Hypertension</u> | <u>not known</u> |
| | DUE TO | |
| | (c) | |

| | | | | | |
|--|---|---|----------|------------------------------|--|
| 11. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | <u>Chronic Cholecystitis</u> | <u>not known</u> |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | | |

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|---|-----------------------|-------------------------------|----------------------------------|-----------------------------------|--|
| 22. I hereby certify that I attended the deceased from <u>May 31, 1955</u> , to <u>Aug. 8, 1955</u> , that I last saw the deceased alive on <u>Aug. 8, 1955</u> and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above. | | | | | |
| SIGNATURE | | (Degree or title) | | DATE SIGNED | |
| <u>R.M. McLaughlin</u> | | <u>M.D.</u> | | <u>Pasadena, Md. Aug. 8, 1955</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) | |
| <u>Burial</u> | <u>Aug. 11-1955</u> | <u>Glen Haven Cemetery</u> | <u>Glen Burnie, Maryland</u> | | |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>Aug. 10, 1955</u> | <u>L.J. DeAlba</u> | <u>R.V. Singleton</u> | | <u>Glen Burnie, Md.</u> | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 11 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07372

7386 CERTIFICATE OF DEATH

Reg. Dist. No. 25

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Hanover</u> | | <u>6 yrs</u> | | TOWN <u>Hanover</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Race Road</u> | | | | STREET ADDRESS (If rural give location) <u>Race Road</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) (First) (Middle) (Last)
<u>Edward</u> <u>George</u> <u>Pumphrey</u> | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>August</u> <u>20</u> , 19 <u>55</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>April 18, 1923</u> | 9. AGE last birthday
<u>32</u> yrs. | 10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machineist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Macey's Machine Shop</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edward L. Pumphrey</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Margaret B. Krause</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215 16 9989</u> | | 17. INFORMANT & ADDRESS
<u>M. Ed. L. Pumphrey</u> <u>Glen Burnie</u> <u>818 Ave. N. 1st</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 411X IMMEDIATE CAUSE (A) <u>Coronary Infarction</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Aortic Insufficiency (Severe)</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rheumatic Heart Disease</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION
<u>11/15/54</u> | | 19b. MAJOR FINDINGS OF OPERATION
<u>Aortic Insufficiency</u> | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>Aug</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 20</u> , 19 <u>55</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>John M. Allen</u> | | M.D. <u>Univ. Hospital</u> | | ADDRESS (Street, city, town, state)
<u>B-22-55</u> | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE HEREOF
<u>Aug 23/55</u> | | NAME OF CEMETERY OR CREMATORY
<u>Glen Haven</u> | | LOCATION (City, town, or county) (State)
<u>Glen Burnie, Md.</u> | |
| 24. REC'D BY REGISTRAR
DATE <u>August 25 1955</u> | | REGISTRAR'S SIGNATURE
<u>Ms. Ida Watson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>W. J. Sengler</u> | | ADDRESS
<u>Glen Burnie, Md.</u> | |

RECEIVED

AUG 26 1955

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

07313

200-1000000

THIS CERTIFICATE IS TO BE COMPLETED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE DEATH AND BY THE REGISTRAR OF DEATHS. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE FAMILY OF THE DECEASED. IT IS TO BE COMPLETED IN THE FOLLOWING MANNER:

1. NAME OF DECEASED: [Handwritten: JOHN DOE]

2. SEX: [Handwritten: MALE]

3. AGE: [Handwritten: 45]

4. DATE OF BIRTH: [Handwritten: JAN 15 1910]

5. PLACE OF BIRTH: [Handwritten: BALTIMORE, MARYLAND]

6. OCCUPATION: [Handwritten: CLERK]

7. CAUSE OF DEATH: [Handwritten: HEART DISEASE]

8. MANNER OF DEATH: [Handwritten: NATURAL]

9. SIGNATURE OF PHYSICIAN: [Handwritten: J. H. SMITH]

10. SIGNATURE OF REGISTRAR: [Handwritten: J. H. SMITH]

11. DATE OF DEATH: [Handwritten: AUG 25 1955]

12. PLACE OF DEATH: [Handwritten: BALTIMORE, MARYLAND]

13. NAME OF FUNERAL HOME: [Handwritten: J. H. SMITH]

14. NAME OF MINISTER: [Handwritten: J. H. SMITH]

15. NAME OF CHURCH: [Handwritten: J. H. SMITH]

16. NAME OF CEMETERY: [Handwritten: J. H. SMITH]

17. NAME OF BURIAL PLACE: [Handwritten: J. H. SMITH]

18. NAME OF CREMATOR: [Handwritten: J. H. SMITH]

19. NAME OF INTERMENT PLACE: [Handwritten: J. H. SMITH]

20. NAME OF INTERMENT PLACE: [Handwritten: J. H. SMITH]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7387 CERTIFICATE OF DEATH

07373

Reg. Dist. No.

| | | | | | | | |
|---|---|--|---------------------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Charles</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| <u>X</u> TOWN <u>Crownsville</u> | | <u>8yrs. 29das.</u> | | TOWN <u>Indian Head</u> | | <u>08X-2</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>10</u> <u>Crownsville State Hospital</u> | | | | <u>✓</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Della</u> | | (Middle) <u>Queen</u> | | (Last) | | (Year) <u>19 55</u> | |
| (Month) <u>Aug.</u> | | (Day) <u>1</u> | | (Year) <u>19 55</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Unknown</u> | 9. AGE last birthday <u>25</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT & ADDRESS <u>Hospital Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>002X Congestive Heart Failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Epileptiform Seizures</u> | | | | | | Known to us since 7/3/47 | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Juvenile Paresis</u> | | | | | | Known to us since 7/3/47 | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Tuberculosis</u> | | | | | | Known to us since 7/3/47 | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/> F. <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/6/55</u> , 19 <u>55</u> , to <u>8/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/1</u> , 19 <u>55</u> , and that death occurred at <u>8:30 a.m.</u> from the causes and on the date stated above.
SIGNATURE <u>Walter Heard Reimer</u> ADDRESS (Street, city, town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>8/1/55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | DATE THEREOF <u>8/4/55</u> | NAME OF CEMETERY OR CREMATORY <u>Hilltop</u> | | LOCATION (City, town, or county) <u>Hilltop</u> | | (State) <u>M.D.</u> | |
| 24. REC'D BY REGISTRAR <u>8/1/55</u> | REGISTRAR'S SIGNATURE <u>R.M. Joyce</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Penny & Co. Inc.</u> | | ADDRESS <u>Wesley Springs Rd.</u> | | | |

07335

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BIRMINGHAM 19

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MASSACHUSETTS DEPARTMENT OF HEALTH-BIRMINGHAM 19

BUREAU V. 2

AUG 5 1955

RECEIVED

Handwritten signature and notes

Handwritten text

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7388

CERTIFICATE OF DEATH

07375

Reg. Dist. No. 24

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL or end give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Glen Burnie</u> | | <u>5 years</u> | | TOWN <u>Glen Burnie</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 Third Ave., S.W.</u> | | | | STREET ADDRESS (If rural give location) <u>403 Third Ave., S.W.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Ida</u> | | (Middle) <u>E.</u> | | (Last) <u>Reynolds</u> | | (Month) <u>August</u> (Day) <u>14</u> (Year) <u>1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Dec. 30, 1872</u> | 9. AGE last birthday <u>82</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Woodsborough, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles W. Harris</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Julia A. Stout</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Lloyd C. Reynolds 401 Third Ave. Glen Burnie Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, General</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug. 22, 1955</u> , to <u>Aug. 14, 1955</u> , that I last saw the deceased alive on <u>Aug. 8, 1955</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Bobby L. Jones, M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>Glen Burnie Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Aug. 17, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u> | | LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 24. REC'D BY REGISTRAR <u>L. J. DeAlba</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>T. V. Shingleton</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| DATE <u>Aug. 18, 1955</u> | | | | | | | |



47

AUG 22 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7389

CERTIFICATE OF DEATH

07376

Reg. Dist. No.

| | | | | | | | |
|---|--------------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>Glen Burnie</u> | | LENGTH OF STAY (in this place) <u>4 mos</u> | | TOWN <u>Glen Burnie</u> | | TOWN <u>Glen Burnie</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>711 Washington Ave.</u> | | | | STREET ADDRESS (If rural give location) <u>711 Washington Ave. Glen GARDENS</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Irvin H. Riegel</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug-3 1955</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>24 May 1897</u> | 9. AGE last birthday <u>58</u> yrs. | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) | 11. IF UNDER 24 HRS. (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher (ret.)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. Hosp. Oregon</u> | | 11. BIRTHPLACE (State or foreign country) <u>Eden Valley, Minnesota</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Benjamin F. Riegel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Minnie Kickbush</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Bess B. Riegel 711 Washington Ave. Glen Burnie, Md</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u> | | | | | | <u>2 HRS.</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>CORONARY ARTERIO SCLEROSIS</u> | | | | | | <u>9 YRS.</u> | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHIECTASIS</u> | | | | | | <u>10 YRS.</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>54</u> , to <u>Aug. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 3</u> , 19 <u>55</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Leon C. Perry</u> | | M.D. <u>2013 A BLVD GLEN BURNIE, MD.</u> | | DATE SIGNED <u>8-3-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>5 August 55</u> | | NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. K. Kingston</u> | | | |
| DATE <u>Aug 5, 1955</u> | | | | ADDRESS | | | |

03578

CERTIFICATE OF DEATH

Reg. Off. No.

1. DEATH OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. TIME OF BIRTH

10. SEX

11. RACE

12. OCCUPATION

13. EDUCATION

14. RELIGION

15. MARITAL STATUS

16. PREVIOUS MARRIAGES

17. PREVIOUS DEATHS

18. PREVIOUS DISEASES

19. PREVIOUS SURGERIES

20. PREVIOUS TRAUMAS

21. PREVIOUS ACCIDENTS

22. PREVIOUS DRUGS

23. PREVIOUS ALCOHOL

24. PREVIOUS TOBACCO

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07377

7390 CERTIFICATE OF DEATH

Reg. Dist. No. 24

| | | | | | | | |
|---|----------------------------------|--|---|--|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Glen Burnie P.O.</u> | | <u>3 yrs</u> | | TOWN <u>Glen Burnie P.O.</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#2 Wells Ave. - Ferndale</u> | | | | STREET ADDRESS (If rural give location) <u>#2 Wells Ave. Ferndale</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Gustav Adolf Schmale</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>August 31, 1955</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>Dec. 9, 1885</u> | 9. AGE last birthday
<u>69</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinists Helper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>B. & O. P. R.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Schmale</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Maria Hilda ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>705 07 9237</u> | | 17. INFORMANT & ADDRESS
<u>Mrs. Mary O. Schmale</u> <u>2 Wells Ave. Ferndale, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERIOSCLEROSIS</u> | | | | | | <u>4 YRS.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>AUG 21, 1953</u> to <u>AUG 31, 1955</u> , that I last saw the deceased alive on <u>8-26, 1955</u> , and that death occurred at <u>5:04 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Leon C. Perry</u> | | DATE THEREOF
<u>Sept. 3/55</u> | | NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Mem. Park</u> | | LOCATION (City, town, or county) (State)
<u>Washington Blvd. Md.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 24. REC'D BY REGISTRAR
<u>L. J. DeAlba</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>R. H. Kingston</u> | | ADDRESS
<u>Glen Burnie, Md.</u> | |

BUREAU V. B.

8 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7391
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 20

| | | | | | | | |
|--|--------------------------------------|--|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>AA</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>AA</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>TOWN HARWOOD</u> | | LENGTH OF STAY (in this place)
<u>40 yrs</u> | | CITY (If outside corporate limits write RURAL and give nearest town)
<u>TOWN HARWOOD</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>00</u> | | | | STREET ADDRESS (If rural, give location)
<u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
<u>Thomas Rehnold SEARS</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Aug 11 1955</u> | | | |
| 5. SEX:
<u>M</u> | 6. COLOR OR RACE:
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
<u>Married Oct 8 1914</u> | 8. DATE OF BIRTH:
<u>40</u> | 9. AGE last birthday: yrs. <u>40</u> | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Former</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Tobacco</u> | | 11. BIRTHPLACE (State or foreign country): <u>Harwood, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME:
<u>Thomas M. Sears</u> | | | | 14. MOTHER'S MAIDEN NAME:
<u>Mary Phipps</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY No.: <u>—</u> | | 17. INFORMANT & ADDRESS:
<u>Thomas Sears, Harwood Md</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Gun shot wound chest</u>
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c) | | | | | | <u>Sudden</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 20. AUTOPSY?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>) | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 11 55 A M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR?
<u>Self inflicted Gun shot</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>John F. [Signature]</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAM. <u>8/13/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify):
<u>Burial</u> | | DATE THEREOF
<u>Aug 13 1955</u> | | NAME OF CEMETERY OR CREMATORY
<u>Harwood</u> | | LOCATION (City, town, or county) (State)
<u>Harwood Md</u> | |
| DATE REC'D BY LOCAL REG.
<u>8/13/55</u> | | REGISTRAR'S SIGNATURE
<u>Benjamin [Signature]</u> | | 24. FUNERAL DIRECTOR
<u>Benjamin [Signature]</u> | | | |
| | | | | ADDRESS | | | |

AUG 23 1955

RECEIVED

7343

CERTIFICATE OF DEATH

Reg. Dist. No.....

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Anne Arundel</i> | | MARYLAND | | STATE <i>Md.</i> | | COUNTY <i>aa.</i> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <i>Annapolis</i> | | 3 yrs. | | OR TOWN <i>Severna Park</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| 90 <i>Homecroft Convalescent Home</i> | | | | <i>McKinsey Rd.</i> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH: (Month) (Day) (Year) | | | |
| <i>Mabel Rowland Shepard</i> | | | | <i>Aug. 31, 1955</i> | | | |
| 5. SEX: <i>F</i> | | 6. COLOR OR RACE: <i>W</i> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i> | | 8. DATE OF BIRTH: <i>January 3, 1870</i> | |
| 9. AGE last birthday: <i>85</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>none</i> | | 11. BIRTHPLACE (State or foreign country): <i>Pittsburg Pa</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME: <i>A. Judson Rowland D.D.</i> | | | | 14. MOTHER'S MAIDEN NAME: <i>Harriet Frick</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> | | | | 16. SOCIAL SECURITY No.: <i>-</i> | | 17. INFORMANT & ADDRESS: <i>Mrs Alfred M Geis Same</i> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| 422.1 Immediate cause (a) <i>Senile degeneration</i> | | | | | | | |
| Antecedent cause(s) (b) <i>Arteriosclerotic Cardio Vascular Disease</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION: | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>March, 1952</i> to <i>8/31, 1955</i> , that I last saw the deceased alive on <i>8/31, 1955</i> , and that death occurred at <i>11:20 P.M.</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Mansel Klawans md</i> | | | | (DEGREE OR TITLE) <i>Annapolis, Md</i> | | DATE SIGNED <i>9/2/55</i> | |
| 23. BURIAL, CREMATION REMOVAL (Specify): <i>Removal</i> | | DATE THEREOF <i>Sept 3 1955</i> | | NAME OF CEMETERY OR CREMATORY <i>Brandywine Baptist Church</i> | | LOCATION (City, town, or county) <i>Downingtown Pa.</i> | |
| DATE REC'D BY LOCAL REG <i>Sept. 7, 1955</i> | | REGISTERAR'S SIGNATURE <i>Wm. J. French</i> | | 24. FUNERAL DIRECTOR <i>W. Jenkins</i> | | ADDRESS <i>5000 York Rd</i> | |

MARGIN RESERVED FOR BINDING

BUREAU V. S.

SEP 8 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7344

CERTIFICATE OF DEATH

07380

Reg. Dist. No. 21

Item 12, Film G187 9-28-55 et

| | | | | | | | |
|--|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)
<u>10</u> TOWN | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Annapolis</u> | | <u>10</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>51</u> <u>U. S. Naval Hospital</u>
<u>Annapolis, Maryland</u> | | STREET ADDRESS (If rural give location)
<u>65 Southgate Ave.</u> | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>Baby Girl</u> <u>SIEVER</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>August 9</u> <u>19</u> <u>55</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>Single</u> | 8. DATE OF BIRTH
<u>9 August 1955</u> | 9. AGE last birthday yrs. <u>2</u> <u>32</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>32</u> | IF UNDER 24 HRS. Hours <u>2</u> Min <u>32</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Newborn</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
— — — — — | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Frank Wilson SIEVER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy MAO GOWIN Kathleen Studd</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT & ADDRESS
<u>Hospital Records & Family</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 1 IMMEDIATE CAUSE (A) <u>Immaturity with prematurity</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2hrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST, (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>9 Aug.</u>, <u>1955</u>, to <u>9 Aug.</u>, <u>1955</u>, that I last saw the deceased alive on <u>9 Aug.</u>, <u>1955</u>, and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>James C. Hodges</u> | | | | DATE SIGNED
<u>9 Aug. 1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>August 11, 55</u> | | NAME OF CEMETERY OR CREMATORY
<u>Naval Cemetery</u> | | LOCATION (City, town, or county) (State)
<u>Annapolis, Maryland</u> | |
| 24. REC'D BY REGISTRAR
<u>August 11, 55</u> | | REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>[Signature]</u>
HOPPING FUNERAL HOME
<u>Annapolis, Md.</u> | | | |

2085313240

CERTIFICATE OF DEATH

07380

| | | | |
|--|--|--|--|
| COUNTY OF <u>ANNAPOLIS</u>
STATE OF <u>MARYLAND</u> | | DECEASED
<u>JOHN J. ROBERTSON</u> | |
| DATE OF DEATH
<u>August 12, 1955</u> | | PLACE OF DEATH
<u>Home</u> | |
| TIME OF DEATH
<u>10:00 AM</u> | | CAUSE OF DEATH
<u>Heart Disease</u> | |
| PLACE OF BIRTH
<u>ANNAPOLIS, MARYLAND</u> | | AGE
<u>65</u> | |
| SEX
<u>Male</u> | | OCCUPATION
<u>Retired</u> | |
| MARITAL STATUS
<u>Married</u> | | EDUCATION
<u>High School</u> | |
| PREVIOUS ILLNESS
<u>None</u> | | MEDICAL HISTORY
<u>None</u> | |
| PHYSICIAN
<u>Dr. J. J. Robertson</u> | | SIGNATURE OF PHYSICIAN
<u>[Signature]</u> | |
| SIGNATURE OF DECEASED
<u>[Signature]</u> | | SIGNATURE OF WITNESSES
<u>[Signature]</u> | |

BUREAU V. S.

AUG 12 1955

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7345

CERTIFICATE OF DEATH

07381

Reg. Dist. No.

Item 8. Film G185 8-17-55 et

| | | | | | | | |
|---|------------------|---|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>A.A. Co.</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>A.A. Co.</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>ANNA POLIS</u> | | | | 10 TOWN <u>ANNA POLIS</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 00 <u>54 SHAW ST</u> | | | | <u>54 SHAW STREET</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>SIMMS</u> | | | | 8 7 19 55 | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>Colored</u> | <u>W</u> | <u>4-16-1893</u> | <u>61</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired</u> | | | | <u>Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John H. Simms</u> | | | | <u>JULIA A. ENNIS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | | | <u>ANNA. Md</u>
<u>CORSINA ALTON, 54 SHAW ST</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO <u>disease</u> | | | | | | 3 months | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from <u>May 5, 1953</u> to <u>August 7, 1955</u> , that I last saw the deceased alive on <u>August 1, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>R. L. Richardson</u> | | <u>8-10-55</u> | | <u>ANNA POLIS NATIONAL</u> | | <u>ANNA POLIS Md</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>BURIAL</u> | | <u>Aug. 9, 1955</u> | | <u>William Reese, #108 W. Wash. St</u> | | <u>ANNA POLIS, Md</u> | |



2017/11/14

1-444-1

24244 27-02

72 W. 12 St.

[illegible]

John Henry

10 APR 11 1964

White Cloud

524 6-11-19

b 27595A

21 Nov 3 5:15 PM

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4. 10. 1957

1944

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

BUREAU V. S.

1955-10-10

RECEIVED

8-10-55 44449-12 National Archives

14-00000

William Brewster 100 West 4th St.

1912-13

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07382

7346

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|--|------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>A.A.</u> | | MARYLAND | | STATE <u>Mo.</u> | | COUNTY <u>A.A.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>10 ANNAPOLIS</u> | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>ANNAPOLIS</u> | | <u>19</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>00 504 Sixth St.</u> | | | | STREET ADDRESS (If rural give location)
<u>504 Sixth St.</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>JOHN</u> (First) <u>H.</u> (Middle) <u>SMITH</u> (Last) | | | | 4. DATE OF DEATH
(Month) <u>8</u> (Day) <u>4</u> (Year) <u>1955</u> | | | |
| 5. SEX
<u>17</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u> | 8. DATE OF BIRTH
<u>7/13/1867</u> | 9. AGE last birthday
<u>88</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CARPENTER CONSTRUCTION</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CONSTRUCTION</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>JOHN SMITH</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>SARAH KIRBY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)
<u>no</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS
<u>MR. HARRY W. SMITH #2</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u> | | | | <u>4 yrs.</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 30, 1954</u> to <u>Aug 4, 1955</u> that I last saw the deceased alive on <u>Aug 4, 1955</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.
SIGNATURE <u>James D. Math</u> M.D. <u>Grinnapolis, Md Aug 5, 1955</u>
DATE <u>Aug 8, 1955</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | DATE THEREOF
<u>8/7/55</u> | | NAME OF CEMETERY OR CREMATORY
<u>HIGH CREST</u> | | LOCATION (City, town, or county) (State)
<u>ANNAPOLIS MD.</u> | |
| 24. REC'D BY REGISTRAR
<u>John M. Tybirk</u> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Tybirk</u> | | ADDRESS
<u>Annapolis</u> | |

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G186 9-13-55 ans

7392

CERTIFICATE OF DEATH

Reg. Dist. No.

07383

| | | | | | | | |
|--|--------------------------------|---|---|--|------------------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Anne Arundel</u> MARYLAND | | | | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> | | | |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Bristol</u> | | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Friendship</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 416</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Hamilton Crosby Stallings Jr</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>8 28 1955</u> | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>March 10, 1924</u> | 9. AGE last birthday <u>31</u> yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Librarian</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Hamilton Crosby Stallings</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Bowen</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT & ADDRESS: <u>Mr Hamilton Stallings, Jr</u> | | | | <u>Friendship</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>816X</u> | | | | (A) <u>Collision & Fire</u> | | | |
| ANTECEDENT CAUSE (S): | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | (B) <u>Auto-Auto collision</u> | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>5</u> | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | | | 21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>Highway</u> | | 21C. WHERE DID (City, or town) (County) (State) INJURY OCCUR? <u>Bristol AA Md</u> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8-28-55 3:00 A.M.</u> | | | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>Collision & Fire</u> | |
| 22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased <u>alive on</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>J.D. Hendricks</u> | | | | ADDRESS <u>Acting Medical Examiner A.A. County</u> | | | |
| DATE SIGNED <u>8-29-55</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | DATE THEREOF <u>8/30/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Friendship Ametery</u> | |
| | | | | LOCATION (City, town, or county) <u>Friendship</u> | | (State) <u>Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>8/30/55</u> | | | | REGISTRAR'S SIGNATURE <u>Eric Wick Helleson</u> | | 24. FUNERAL DIRECTOR <u>William H. Hutchins</u> | |
| | | | | ADDRESS <u>Williams H. Hutchins, Owings, Md.</u> | | | |

RECEIVED

SEP 2 1955

BUREAU V. 8

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--------------------------------|---|--------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Anne Arundel</i> | | MARYLAND | | STATE <i>md</i> | | COUNTY <i>Anne Arundel</i> | |
| CITY (If outside corporate limits, write RURAL OR TOWN) <i>Bristol</i> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Friendship</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Route 416</i> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) | | | |
| First Middle Last <i>Oscar Bowen Stallings</i> | | | | OF DEATH: <i>8 28 1955</i> | | | |
| 5. SEX: <i>Male</i> | 6. COLOR OR RACE: <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i> | 8. DATE OF BIRTH: <i>Oct 9, 1928</i> | 9. AGE last birthday <i>26</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>U. S. Navy</i> | | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Seaman 1st C.</i> | | 11. BIRTHPLACE (State or foreign country): <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME: <i>Hamilton Crosby Stallings</i> | | | | 14. MOTHER'S MAIDEN NAME: <i>Muriel Elizabeth Bowen</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or date of service) <i>yes April 1952 Still active</i> | | | | 16. SOCIAL SECURITY NO. <i>-</i> | | | |
| 17. INFORMANT & ADDRESS: <i>Mr Hamilton Stallings, Friendship</i> | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <i>Collision & Fire</i> | | | | | | instantaneous | |
| ANTECEDENT CAUSE (B) <i>Auto-Auto collision</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>Highway</i> | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>Bristol, Anne A. Md.</i> | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>8-28-55 3:00 A.M.</i> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>Collision & fire</i> | | | |
| 22. I hereby certify that I attended the deceased from <i>1955</i> , 19 <i>55</i> , to <i>1955</i> , 19 <i>55</i> , that I last saw the deceased <i>alive on</i> <i>8/30/55</i> , and that death occurred at <i>3:00 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>H. Hendricks, Acting Medical Examiner</i> | | ADDRESS <i>MD</i> | | DATE SIGNED <i>8-29-55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>8/30/55</i> | | NAME OF CEMETERY OR CREMATORY <i>Friendship Cemetery</i> | | LOCATION (City, town, or county) (State) <i>Friendship, Md.</i> | |
| DATE REC'D BY LOCAL REGISTRAR <i>8/30/55</i> | | REGISTRAR'S SIGNATURE <i>Eric W. Williams</i> | | 24. FUNERAL DIRECTOR <i>Wm. H. Hendricks</i> | | ADDRESS <i>Owings, Md.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1955

BUREAU V. S.

7394

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Pasadena LENGTH OF STAY (in this place) 4.5 yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Poplar Ridge Road, Poplar Ridge, Pasadena P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Pasadena P.O.
 STREET ADDRESS (If rural give location) Poplar Ridge Road, Poplar Ridge, Pasadena P.O.

3. NAME OF DECEASED:

(First) Thomas
 (Type or Print)

(Middle)

(Last)

4. DATE OF DEATH:

(Month) (Day) (Year)
August 22 1955

5. SEX:

Male

5. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widow

8. DATE OF BIRTH:

April 29-1865

9. AGE last birthday:

90 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Kindy man

10b. KIND OF BUSINESS OR INDUSTRY:

Roger Boat yard

11. BIRTHPLACE (State or foreign country):

Baltimore Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

P - Tracey

14. MOTHER'S MAIDEN NAME:

Nancy Anne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

NONE

17. INFORMANT & ADDRESS:

Frank S. Tracey, Poplar Ridge Road, Pasadena P.O. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
 Immediate cause (a) Coronary Heart Failure

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

2 weeks - not known

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 22, 1955, to August 22, 1955, that I last saw the deceased

alive on August 21, 1955, and that death occurred at 1:10 A.M. from the causes and on the date stated above.

SIGNATURE R.M. McLaughlin

(Degree or title)

M.D.

ADDRESS

Pasadena Md.

DATE SIGNED

August 22, 1955

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Aug. 24-1955

NAME OF CEMETERY OR CREMATORY

Maryth Church Cemetery, Maryland

LOCATION (City, town, or county)

Maryth, Maryland

(State)

DATE REC'D BY LOCAL REGISTRAR

August 24, 1955

REGISTRAR'S SIGNATURE

L. J. D'Alba

24. FUNERAL DIRECTOR

R. V. Singleton

ADDRESS

Hen. Barnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1955

BUREAU V. S.

Tracey

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07386

7395

CERTIFICATE OF DEATH

Reg. Dist. No. 20

Items 2.9, Film 185 9-1-55 et

1. PLACE OF DEATH

COUNTY **Ann Arundel**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Shoreham Beach**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland**COUNTY **A. A.**

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Edgewater

STREET ADDRESS

(If rural give location)

Route # 1, Box 399

3. NAME OF DECEASED (Type or Print)

(First) **ISABELLE** (Middle)

(Last)

EVELYN ISABEL TUCKER

4. DATE OF DEATH

(Month)

(Day)

(Year)

Aug. 22nd. 1955

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

m

8. DATE OF BIRTH

Feb 8th. 1898

9. AGE last birthday

56/ 57 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Ricker

14. MOTHER'S MAIDEN NAME

Isabel Binnix

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Chas E. Robertson

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X IMMEDIATE CAUSE (A)

(A)

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While at work ☐Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug. 15**, 19**55**, to **Aug. 22**, 19**55**, that I last saw the deceased alive on **Aug. 22**, 19**55**, and that death occurred at **8:25** M, from the causes and on the date stated above.

SIGNATURE

Emily H. Wilson

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

Robertson and**8/25/55**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**Aug 25, 1955****Ft Lincoln****Colmar Manor Md****8/25/55**

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE **Aug. 25, 1955****Edward Collins****J. William Lee's Sons Co.****Wash. D.C.**

AUG 26 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07387

7347

CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <u>Annapolis</u> | | | | TOWN <u>Annapolis</u> | | 10 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 63 <u>Anne Arundel General</u> | | | | <u>Spa Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) (Middle) (Last) | | | | | | | |
| <u>CHARLES J VICKERS</u> | | | | <u>AUGUST 21 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) | | |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>Feb. 14, 1901</u> | <u>54 yrs.</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Chauffeur</u> | | <u>City Fire Dept</u> | | <u>Baltimore, Maryland</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Unknown</u> | | | | <u>Minnie (?)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>no</u> | | <u>214-05-0335 Mrs Margaret Vickers- Wife- same as # 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| <u>592X</u> IMMEDIATE CAUSE (A) <u>Uremia + Congestive failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic nephritis</u> | | | | | | <u>6 wks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u> | | | | | | <u>4+ mos</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | <u>4+ mos</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| <u>5/12/55</u> | | <u>left pyonephrosis</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>4/26/55</u>, 19<u>55</u>, to <u>8/21/55</u>, that I last saw the deceased alive on <u>9/21/55</u>, 19<u>55</u>, and that death occurred at <u>8 P</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>Frank M. Shady</u> | | | | <u>M.D. 63 College Ave Annapolis</u> | | <u>9/2/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Aug. 25, 1955</u> | | <u>Cedar Bluff Cemetery</u> | | <u>Annapolis, Maryland</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Aug. 25, 55</u> | | <u>[Signature]</u> | | <u>Hopping Funeral Home</u> | | <u>Annapolis, Md</u> | |

05382

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957 - CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. CHIEF ATTENDING PHYSICIAN OR DOCTOR

2. PLACE OF DEATH

3. DATE OF DEATH

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF BIRTH

11. MARITAL STATUS

12. RACE

13. SEX

14. AGE

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. TIME OF DEATH

18. PLACE OF BIRTH

19. MARITAL STATUS

20. RACE

21. SEX

22. AGE

23. CAUSE OF DEATH

24. MANNER OF DEATH

25. TIME OF DEATH

26. PLACE OF BIRTH

27. MARITAL STATUS

28. RACE

29. SEX

30. AGE

31. CAUSE OF DEATH

32. MANNER OF DEATH

33. TIME OF DEATH

34. PLACE OF BIRTH

35. MARITAL STATUS

36. RACE

37. SEX

38. AGE

39. CAUSE OF DEATH

40. MANNER OF DEATH

41. TIME OF DEATH

42. PLACE OF BIRTH

43. MARITAL STATUS

44. RACE

45. SEX

46. AGE

47. CAUSE OF DEATH

48. MANNER OF DEATH

49. TIME OF DEATH

50. PLACE OF BIRTH

51. MARITAL STATUS

52. RACE

53. SEX

54. AGE

55. CAUSE OF DEATH

56. MANNER OF DEATH

57. TIME OF DEATH

58. PLACE OF BIRTH

59. MARITAL STATUS

60. RACE

61. SEX

62. AGE

63. CAUSE OF DEATH

64. MANNER OF DEATH

65. TIME OF DEATH

66. PLACE OF BIRTH

67. MARITAL STATUS

68. RACE

69. SEX

70. AGE

71. CAUSE OF DEATH

72. MANNER OF DEATH

73. TIME OF DEATH

74. PLACE OF BIRTH

75. MARITAL STATUS

76. RACE

77. SEX

78. AGE

79. CAUSE OF DEATH

80. MANNER OF DEATH

81. TIME OF DEATH

82. PLACE OF BIRTH

83. MARITAL STATUS

84. RACE

85. SEX

86. AGE

87. CAUSE OF DEATH

88. MANNER OF DEATH

89. TIME OF DEATH

90. PLACE OF BIRTH

91. MARITAL STATUS

92. RACE

93. SEX

94. AGE

95. CAUSE OF DEATH

96. MANNER OF DEATH

97. TIME OF DEATH

98. PLACE OF BIRTH

99. MARITAL STATUS

100. RACE

101. SEX

102. AGE

103. CAUSE OF DEATH

104. MANNER OF DEATH

105. TIME OF DEATH

106. PLACE OF BIRTH

107. MARITAL STATUS

108. RACE

109. SEX

110. AGE

111. CAUSE OF DEATH

112. MANNER OF DEATH

113. TIME OF DEATH

114. PLACE OF BIRTH

115. MARITAL STATUS

116. RACE

117. SEX

118. AGE

119. CAUSE OF DEATH

120. MANNER OF DEATH

121. TIME OF DEATH

122. PLACE OF BIRTH

123. MARITAL STATUS

124. RACE

125. SEX

126. AGE

127. CAUSE OF DEATH

128. MANNER OF DEATH

129. TIME OF DEATH

130. PLACE OF BIRTH

131. MARITAL STATUS

132. RACE

133. SEX

134. AGE

135. CAUSE OF DEATH

136. MANNER OF DEATH

137. TIME OF DEATH

138. PLACE OF BIRTH

139. MARITAL STATUS

140. RACE

141. SEX

142. AGE

143. CAUSE OF DEATH

144. MANNER OF DEATH

145. TIME OF DEATH

146. PLACE OF BIRTH

147. MARITAL STATUS

148. RACE

149. SEX

150. AGE

151. CAUSE OF DEATH

152. MANNER OF DEATH

153. TIME OF DEATH

154. PLACE OF BIRTH

155. MARITAL STATUS

156. RACE

157. SEX

158. AGE

159. CAUSE OF DEATH

160. MANNER OF DEATH

161. TIME OF DEATH

162. PLACE OF BIRTH

163. MARITAL STATUS

164. RACE

165. SEX

166. AGE

167. CAUSE OF DEATH

168. MANNER OF DEATH

169. TIME OF DEATH

170. PLACE OF BIRTH

171. MARITAL STATUS

172. RACE

173. SEX

174. AGE

175. CAUSE OF DEATH

176. MANNER OF DEATH

177. TIME OF DEATH

178. PLACE OF BIRTH

179. MARITAL STATUS

180. RACE

181. SEX

182. AGE

183. CAUSE OF DEATH

184. MANNER OF DEATH

185. TIME OF DEATH

186. PLACE OF BIRTH

187. MARITAL STATUS

188. RACE

189. SEX

190. AGE

191. CAUSE OF DEATH

192. MANNER OF DEATH

193. TIME OF DEATH

194. PLACE OF BIRTH

195. MARITAL STATUS

196. RACE

197. SEX

198. AGE

199. CAUSE OF DEATH

200. MANNER OF DEATH

201. TIME OF DEATH

202. PLACE OF BIRTH

203. MARITAL STATUS

204. RACE

205. SEX

206. AGE

207. CAUSE OF DEATH

208. MANNER OF DEATH

209. TIME OF DEATH

210. PLACE OF BIRTH

211. MARITAL STATUS

212. RACE

213. SEX

214. AGE

215. CAUSE OF DEATH

216. MANNER OF DEATH

217. TIME OF DEATH

218. PLACE OF BIRTH

219. MARITAL STATUS

220. RACE

221. SEX

222. AGE

223. CAUSE OF DEATH

BUREAU V. S.

AUG 26 1955

RECEIVED

MARYLAND

7348

07388

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, Film G185 8-23-55 et

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH
COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
TOWN <u>Annapolis</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>213 - Clay St Annapolis, Md.</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>
TOWN <u>Annapolis</u>
STREET ADDRESS <u>213 - Clay Street</u> | |
| 3. NAME OF DECEASED
(First) <u>Alice</u> (Middle) <u>White</u> (Last) <u>White</u> | | 4. DATE OF DEATH
(Month) <u>August</u> (Day) <u>14</u> (Year) <u>1955</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Colored</u> | 7. SINGLES, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>December 25, 1911</u> AGE last birthday <u>43</u> yrs. <u>11</u> months <u>14</u> days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>South Carolina USA</u> | |
| 13. FATHER'S NAME
<u>James Pew</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY No. <u>110 - Clay St Annapolis, Md.</u> | |
| 17. INFORMANT AND ADDRESS
<u>(Husband) Paul White; 215 - Clay Street</u> | | | |

| | | | |
|---|--|---------------------------|---|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | INTERVAL BETWEEN ONSET AND DEATH
<u>5 Months</u> |
| 331X
Immediate cause (a) <u>Cerebral Hemorrhage</u> | | | |
| Antecedent cause(s) (b) <u>Essential Hypertension</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Essential Hypertension</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from Jan, 1955, to 8/14/, 1955, that I last saw the deceased alive on 8/11/, 1955, and that death occurred at 6:50 P. m., from the causes and on the date stated above.

| | | | | | |
|---|--|---|--|---|--|
| SIGNATURE <u>R. K. Buchanan</u> (Degree or title) <u>M.D.</u> | | ADDRESS <u>110 - Clay St Annapolis, Md.</u> | | DATE SIGNED <u>8/14/55</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u> | | LOCATION (City, town, or county) <u>Annapolis Neck, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>Aug. 17, 1955</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 24. FUNERAL DIRECTOR <u>William Reese II</u> ADDRESS <u>108 W. Wash. St. Annapolis, Md.</u> | |

MARGIN RESERVED FOR BINDING

01338

1955

1955

RECEIVED



BUREAU V. S.

AUG 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this filing has been completed, the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7396

CERTIFICATE OF DEATH

07389

Reg. Dist. No.

| | | | | | | | |
|---|------------------|---|----------------------|---|-----------------|---|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| X TOWN <u>Mallusville</u> | | <u>2 Months</u> | | TOWN <u>303 Fifth Ave. North East.</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS | | | |
| <u>90 Linda Nursing Home</u> | | | | <u>Glen Burnie</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) (Middle) (Last) | | | | (Month) (Day) (Year) | | | |
| <u>Louise Marie Widenhoff</u> | | | | <u>August 25 - 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | |
| <u>Female</u> | <u>White</u> | <u>Widow</u> | <u>Jan. 18, 1877</u> | <u>78</u> yrs. | Months | Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housework (Ret.)</u> | | <u>Own Home</u> | | <u>Germany</u> | | <u>U. S. A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Herman J. Warkentin</u> | | | | <u>Justine Chavakovsky</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>None</u> | | <u>E. W. R. Stallings</u> <u>26 Normal Terrace</u> <u>Towson 4 Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 581.0 IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <u>Cerebral of the liver</u> | | | | <u>+ 2 months</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>7/8/55</u> , 19 <u>55</u> , to <u>8/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>55</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M. D. | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>Gustave F. Anter</u> | | <u>Glen Burnie Md.</u> | | <u>8/26/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Aug. 27 - 1955</u> | | <u>Cedar Hill Cemetery</u> | | <u>Brooklyn - R.F.D. Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>Aug 30, 1955</u> | | <u>Lutherie M. Jeyar</u> | | <u>R. V. Singleton</u> | | <u>Glen Burnie</u> | |
| | | <u>L. J. DeAlba</u> | | | | | |

05283

CERTIFICATE OF DEATH

1950

Form No. 100

1. USUAL RESIDENCE (Street or location)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. COLOR

15. HEIGHT

16. WEIGHT

17. BLOOD TYPE

18. HUSBAND'S NAME

19. WIFE'S NAME

20. CHILDREN'S NAMES

21. SOCIAL SECURITY NUMBER

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

24. SIGNATURE OF PHYSICIAN

25. SIGNATURE OF CLERK

26. SIGNATURE OF REGISTRAR

27. SIGNATURE OF JUDGE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CORONER

30. SIGNATURE OF DISTRICT ATTORNEY

31. SIGNATURE OF COUNTY CLERK

32. SIGNATURE OF CITY CLERK

33. SIGNATURE OF TOWNSHIP CLERK

34. SIGNATURE OF VILLAGE CLERK

35. SIGNATURE OF POST OFFICE CLERK

36. SIGNATURE OF SCHOOL CLERK

37. SIGNATURE OF CHURCH CLERK

38. SIGNATURE OF SYNAGOGUE CLERK

39. SIGNATURE OF MOSQUE CLERK

40. SIGNATURE OF TEMPLE CLERK

41. SIGNATURE OF MONASTERY CLERK

42. SIGNATURE OF CONVENT CLERK

43. SIGNATURE OF NUNNERY CLERK

44. SIGNATURE OF PRIESTLY CLERK

45. SIGNATURE OF BISHOP'S CLERK

46. SIGNATURE OF ARCHBISHOP'S CLERK

47. SIGNATURE OF CARDINAL'S CLERK

48. SIGNATURE OF PAPAL CLERK

49. SIGNATURE OF VATICAN CLERK

50. SIGNATURE OF HOLY SEE CLERK

51. SIGNATURE OF ROMAN CLERK

52. SIGNATURE OF LITURGY CLERK

53. SIGNATURE OF SACRAMENT CLERK

54. SIGNATURE OF Eucharist CLERK

55. SIGNATURE OF BAPTISM CLERK

56. SIGNATURE OF CONFIRMATION CLERK

57. SIGNATURE OF ORDINATION CLERK

58. SIGNATURE OF TRANSUBSTANTIATION CLERK

59. SIGNATURE OF COMMUNION CLERK

60. SIGNATURE OF ANOINTING CLERK

61. SIGNATURE OF EXORCISM CLERK

62. SIGNATURE OF EXorcism CLERK

63. SIGNATURE OF EXorcism CLERK

64. SIGNATURE OF EXorcism CLERK

65. SIGNATURE OF EXorcism CLERK

66. SIGNATURE OF EXorcism CLERK

67. SIGNATURE OF EXorcism CLERK

68. SIGNATURE OF EXorcism CLERK

69. SIGNATURE OF EXorcism CLERK

70. SIGNATURE OF EXorcism CLERK

RECEIVED

BUREAU V. S.

AUG 31 1950

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7397 CERTIFICATE OF DEATH

07390

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|------------------------|---|-------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Baltimore City</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Crownsville</u> | | <u>4 yrs. 23 das.</u> | | TOWN <u>Baltimore</u> | | <u>3V01-4</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>2504 Woodbrook Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Lewis</u> (Middle) (Last) <u>Winston</u> | | | | (Month) (Day) (Year) | | | |
| | | | | <u>August 1 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>M</u> | <u>Negro</u> | <u>Widowed</u> | <u>4/8/86</u> | <u>69</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Winston</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Liza</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT & ADDRESS <u>Hospital Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>422.1</u> IMMEDIATE CAUSE (A) <u>Pulmonary edema</u> | | | | | | <u>6 hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Insufficiency</u> | | | | | | <u>Known to us since 7/9/51</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u> | | | | | | <u>Known to us since 7/9/51</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/6</u> , 19 <u>55</u> , to <u>August 1</u> , 19 <u>55</u> , that I last saw the deceased <u>alive on 8/1/55</u> , and that death occurred at <u>2:35</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Heckford Heard Reiman</u> | | | | ADDRESS (Street, city, town, state) <u>8/1/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Aug. 3, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>St. Auburn Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>T. M. Joyce</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson</u> | | ADDRESS <u>1700 Daniel Hill Ave.</u> | |
| DATE <u>Aug 3, 1955</u> | | | | | | | |

03300

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1955 CERTIFICATE OF DEATH

Form 100-100-100

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. PLACE OF DEATH

13. CAUSE OF DEATH

14. MANNER OF DEATH

15. PLACE OF DEATH

16. DATE OF DEATH

17. TIME OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. MANNER OF DEATH

21. PLACE OF DEATH

22. DATE OF DEATH

23. TIME OF DEATH

24. PLACE OF DEATH

25. CAUSE OF DEATH

26. MANNER OF DEATH

27. PLACE OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

30. PLACE OF DEATH

31. CAUSE OF DEATH

32. MANNER OF DEATH

33. PLACE OF DEATH

34. DATE OF DEATH

35. TIME OF DEATH

36. PLACE OF DEATH

37. CAUSE OF DEATH

38. MANNER OF DEATH

39. PLACE OF DEATH

40. DATE OF DEATH

41. TIME OF DEATH

42. PLACE OF DEATH

43. CAUSE OF DEATH

44. MANNER OF DEATH

45. PLACE OF DEATH

46. DATE OF DEATH

47. TIME OF DEATH

48. PLACE OF DEATH

49. CAUSE OF DEATH

50. MANNER OF DEATH

51. PLACE OF DEATH

52. DATE OF DEATH

53. TIME OF DEATH

54. PLACE OF DEATH

55. CAUSE OF DEATH

56. MANNER OF DEATH

57. PLACE OF DEATH

58. DATE OF DEATH

59. TIME OF DEATH

60. PLACE OF DEATH

BUREAU V. S.

AUG 2 1955

RECEIVED

the record here of the same

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07391

7349 CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | | | | | | | |
|---|-----------------------------|--|-----------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Anne Arundel</i> | | STATE <i>MARYLAND</i> | | STATE <i>47X-3</i> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| 10 TOWN <i>Annapolis</i> | | | | TOWN <i>Washington D.C.</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel Gen.</i> | | | | STREET ADDRESS (If rural give location) <i>Annapolis Md</i> ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <i>George Wright</i> | | | | <i>Aug 27 19 55</i> | | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>Col</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>5/11/1905</i> | 9. AGE last birthday <i>50</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>Georgia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>?</i> | | | | 14. MOTHER'S MAIDEN NAME <i>?</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>049-07-5484</i> | | 17. INFORMANT & ADDRESS <i>Mary Wright</i> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 410X IMMEDIATE CAUSE (A) <i>Cardiac Failure</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2h.</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Mitral Stenosis</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>no</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>8/27/55</i> , 19....., to <i>8/27/55</i> , 19....., that I last saw the deceased alive on <i>8/27/55</i> , 19....., and that death occurred at <i>5:29</i> P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Therese H. Johnson M.D.</i> | | | | ADDRESS (Street, city, town, state) <i>37 Cabot Street, Annapolis, Md.</i> | | DATE SIGNED <i>8/27/55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>8/31/55</i> | | NAME OF CEMETERY OR CREMATORY <i>Arlington National</i> | | LOCATION (City, town, of county) (State) <i>Arlington. V.A.</i> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>Wm. J. French</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>JOSEPH S. CORNISH-2121-105X</i> | | ADDRESS <i>Licenses NO. 58. D.C. N.W.</i> | |
| DATE <i>Aug. 30, 1955</i> | | | | | | | |

07391

MARYLAND STATE DEPT. OF HEALTH-BALTIMORE 18

1919 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH OF MARYLAND

STATE OF MARYLAND

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
CITY
COUNTY
STATE

DATE OF DEATH
PLACE OF DEATH
CITY
COUNTY
STATE

CAUSE OF DEATH
MANNER OF DEATH
DISEASE OR INJURY
IMMEDIATE CAUSE
MEDICAL OPINION

PREVIOUS ILLNESS
TREATMENT

DATE OF EXAMINATION
PLACE OF EXAMINATION
CITY
COUNTY
STATE

SIGNATURE OF PHYSICIAN
DATE

SIGNATURE OF REGISTRAR
DATE

SIGNATURE OF CLERK
DATE

SIGNATURE OF JURY
DATE

SIGNATURE OF JURY
DATE

SIGNATURE OF JURY
DATE

SIGNATURE OF JURY
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DATE

SIGNATURE OF JURY
DATE

BUREAU V. S.

AUG 31 1955

RECEIVED

ENCLOSURE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07392
21

Reg. Dist. No.....

7350

| | | | | | | | |
|--|------------------|--|----------------------|---|-----------------|----------------------------------|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| TOWN <u>Annapolis</u> | | | | TOWN <u>Annapolis</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>51 Lafayette Ave</u> | | | | <u>51 Lafayette Ave</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| <u>SAMUEL ZELKOWITZ</u> | | | | <u>AUGUST 26, 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>April 3, 1871</u> | <u>84</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Retired Merchant</u> | | <u>Hardware store</u> | | <u>Lithuania</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Unknown</u> | | | | <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>---</u> | | <u>?</u> | | <u>Mrs Sarah Zelkowitz- Wife- same as # 2</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 1. IMMEDIATE CAUSE (A) <u>420.0 coronary occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 2. ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u> | | | | | | <u>3 days</u> | |
| 3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>diabetes mellitus</u> | | | | | | <u>15 yrs.</u> | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan. 1955</u> , to <u>Aug. 26, 1955</u> , that I last saw the deceased alive on <u>Aug. 25, 1955</u> , and that death occurred at <u>4:30 P.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>S. Bonnick</u> | | | | DATE SIGNED <u>8/27/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | | | <u>August 28, 55</u> | | <u>Kneseth Israel Cem.</u> | |
| 24. REC'D BY REGISTRAR | | | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>8-28-1955</u> | | | | <u>Hopping Funeral Home</u> | | <u>Annapolis, Md.</u> | |

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7351 CERTIFICATE OF DEATH

07393

Reg. Dist. No. 24

| | | | | | | | |
|--|------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>AnneArundel</u> | | STATE <u>MARYLAND</u> | | STATE <u>New York</u> | | COUNTY <u>Monroe</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | OR | |
| 10 TOWN <u>Annapolis, Maryland</u> | | 8mos. | | TOWN <u>Rochester</u> | | 69x.3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Station Dispensary</u> | | | | STREET ADDRESS (If rural give location) <u>1131 Bay Street</u> ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Albert Eugene</u> (Middle) <u>ZETTLEMOYER</u> (Last) | | | | (Month) <u>Aug.</u> (Day) <u>2</u> (Year) <u>19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | Cauc. | Divorced | 14 Dec. 1924 | 30 yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>U.S. Navy</u> | | <u>U.S. Navy</u> | | <u>Williamsport, Penna</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Fred L. ZETTLEMOYER</u> | | | | <u>Helen B. (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| Yes <u>11-6-42 - 8-2-55</u> | | | | <u>Official Naval Records</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema due to Heart Disease #434.2</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Co ronary Arteriosclerosis # 420.1</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | M. | | | | | |
| 22. I hereby certify that I attended the deceased from <u>May</u> 19 <u>55</u> , to <u>1 Aug</u> 19 <u>55</u> , that I last saw the deceased alive on <u>1 Aug.</u> 19 <u>55</u> , and that death occurred at <u>0705 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>W.T. Medic</u> | | | | ADDRESS (Street, city, town, state) <u>U.S. Naval Station, Annapolis, Md.</u> DATE SIGNED <u>8-2-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| Removal | | <u>August 4, 55</u> | | to <u>Rochester, New York</u> | | | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>August 4, 55</u> | | <u>[Signature]</u> | | <u>[Signature]</u> | | <u>HOPPING FUNERAL HOME</u> | |

CERTIFICATE OF DEATH

01303

26

| | | | | | |
|----------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. DATE OF DEATH | | 5. TIME OF DEATH | | 6. PLACE OF DEATH | |
| 7. CAUSE OF DEATH | | 8. MANNER OF DEATH | | 9. SIGNATURE OF PHYSICIAN | |
| 10. SIGNATURE OF REGISTRAR | | 11. SIGNATURE OF WITNESS | | 12. SIGNATURE OF DECEASED | |

BUREAU V. S.

AUG 5 1955

RECEIVED

NO FURTHER CORRECTIONS
 THE REGISTRAR OF DEATHS
 MASSACHUSETTS
 AUGUST 5, 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07394

7352 **CERTIFICATE OF DEATH**

Reg. Dist. No. 21

| | | | | | | | |
|--|------------------------------|--|---|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Anne Arundel</u> | | STATE <u>Maryland</u> | | COUNTY <u>Anne Arundel</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>ANNAPOLIS</u> | | <u>50 yrs.</u> | | TOWN <u>Annapolis</u> | | <u>10</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. Gen. Hosp.</u> | | | | STREET ADDRESS (If rural give location) <u>96 East St.</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last)
<u>OSCAR ANTON ZINDORF</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>Aug. 28, 1955</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH
<u>April 11, 1900</u> | 9. AGE last birthday
<u>55</u> yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MECHANIC Heating</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Heating</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Dayton Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JOSEPH GILBERT ZINDORF</u> | | | | 14. MOTHER'S MARDEN NAME
<u>KATHERINE ANGEL BECK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>220-05-9592</u> | | 17. INFORMANT'S ADDRESS
<u>MRS. FAY BASHAM</u>
<u>96 East St. Annapolis</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 148X IMMEDIATE CAUSE (A) <u>Hemorrhage internal</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of throat</u> | | | | 1 year | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION
<u>March 1955</u> | | 19b. MAJOR FINDINGS OF OPERATION
<u>Cancer of throat</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug 15, 1955</u> to <u>Aug 28, 1955</u> that I last saw the deceased alive on <u>Aug 28, 1955</u> and that death occurred at <u>6:25 P.M.</u> from the causes and on the date stated above.
SIGNATURE <u>Jerse F. Wilkins</u> DATE SIGNED <u>8/28/55</u>
ADDRESS (Street, city, town, state) <u>98 Cathedral St. Annapolis Md.</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>8-31-55</u> | | NAME OF CEMETERY OR CREMATORY
<u>Hillcrest</u> | | LOCATION (City, town, or county) (State)
<u>Annapolis Md</u> | |
| 24. RECEIVED BY REGISTRAR
<u>John M. Laylor</u> | | REGISTRAR'S SIGNATURE
<u>John M. Laylor</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Laylor</u> | | ADDRESS
<u>Annapolis Md</u> | |
| DATE <u>Aug 29, 1955</u> | | | | | | | |

ENCLOSURE

RECEIVED
U.S. MARSHAL SERVICE
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.
AUG 30 1955

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF CLERK

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